Person-Centered Planning

Preparation and Procedure Guide

4th Edition

December, 2008

Adult Developmental Services
Maine Department of Health and Human Services

The Maine Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, age or national origin in admission to, access to, or operations of its programs, services or activities, or its hiring or employment practices.

This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973 as amended, the Age Discrimination Act of 1975 and the Maine Human Rights Act.

Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to the DDHHS ADA/EEO Compliance Coordinator, SHS #11, Augusta, ME 04333-0011; (207)-287-4289 (voice); 800-606-0215 (TTY).

Individuals who need auxiliary aids or services for effective communication in programs and services of DHHS are invited to make their needs and preferences known to the ADA/EEO Compliance Coordinator.

This information is available in alternate formats upon request.

Printed under appropriation # 010 14A 1217 60

Person-Centered Planning Preparation and Procedure Guide
4th Edition, September 2008

Table of Contents

-Continued on next page-

I. Introduction

Person-Centered Planning is the cornerstone of a person-centered approach to supporting people to live meaningful lives. It holds great possibilities when people come together and find ways to make dreams come true. Planning with people can be creative, joyous, and tremendously satisfying, even when it involves a great deal of sustained effort. It is difficult, if not impossible, for Person-Centered Planning to be truly effective if it is not supported by person-centered attitudes and practices that enable the plan to become reality.

Since 1991 Maine has sought to instill person-centered practices in its services to adults with intellectual disabilities or autism. At the same time, there has been increased emphasis on procedures that meet
legal requirements and provide for consistency and accountability. There is inherent tension between the interests of a person and the interests of a service system. One of the greatest challenges of doing Person-Centered Planning within a service system is to keep the person as the primary focus, and not to let the planning process become a bureaucratic exercise in simply following procedures and meeting minimal requirements. The purpose of planning is not simply to comply with regulations, but to increase the person's opportunities to live life as fully as possible.

The procedures described in this booklet are the minimum requirements that fulfill the conditions of the Community Consent Decree, MaineCare funding, and other laws or regulations. Some of these procedures are specifically required for class members of the Community Consent Decree (see "Who's Who in Person-Centered Planning", pg. 5 for a definition of class member). These procedures are also recommended, although not required, for persons who are not class members. Citations that begin with Roman numerals (e.g., VII.4.a) refer to the Community Consent Decree. Citations beginning with 34-B MRSA refer to Maine state law. Requirements are highlighted in bold face, (e.g., "…the team **must** …"). Excerpts from the Decree and other sources of requirements pertaining to Person-Centered Planning are in the Appendix. Internet links to many of these sources are also provided either in the main body of this Guide or in the Appendix.

Everyone who participates in the Person-Centered Planning Process is encouraged to think and act beyond these minimum requirements in order to fully achieve the greatest potential that person-centered planning can offer. There is a wealth of information and material available to support thoughtful and creative planning with people. Some of these resources are listed in the Appendix. We encourage you to take advantage of training and materials that can increase your understanding and your abilities in this most important aspect of supporting people to live full and meaningful lives.

Standard forms used in the PCP process are indicated by *italics.* The forms and detailed instructions for each form can be downloaded from http://www.maine.gov/dhhs/oads/disability/ds/pcp-action-plan/forms.htm

---

☞ Helpful pointers for Planning Process Coordinators (PPCs) are highlighted in boxes like this throughout this guide.

Examples or commentaries on certain points are highlighted in boxes without the pointer.

What is Person-Centered Planning?

There are many aspects of Person-Centered Planning. Here are some statements from different sources about Person-Centered Planning.

> Person-Centered Planning is one way of figuring out where someone is going and what kind of supports they need to get there. Part of it is asking the person, their family, friends, and people who work with him or her about the things he or she wants to do and what he or she can do well. It is also about finding out what things get in the way of doing the things the person wants to do. If people can't talk for themselves, then it's important to spend time with them and to ask others who know them well. – *It's My Choice, Minnesota Governor's Council on Developmental Disabilities*

Person-Centered Planning is a process based in *relationships*. There are several *phases,* which include different *conversations* on different *occasions* among different *people.* *–DHHS training handout*

> Person-Centered Planning is a dynamic and continuous process that is always changing. One of the challenges of this process is to honor the person's preferences and to support informed decision-making while making sure that essential issues are addressed. The person's interests and preferences determine the agenda. This becomes a greater challenge when the person relies on others to understand and communicate their perceived interests.
>
> *–PCP Procedure Guide 2001*

> "…Person-Centered planning [is a] process where needs and desires of the person are articulated and identified. Personal desires and needs **shall** be recorded without respect to whether those desires are reasonably achievable or the needs are presently capable of being addressed. In cases where resources required to address identified needs … are not available, the planning team **shall** develop an interim plan based on available services which:
>
> a) addresses the needs … as nearly as possible, and
>
> b) identifies steps toward meeting the person's actual identified needs.
>
> The planning process **shall** include persons chosen by the person and others who can be anticipated to assist the person in productive pursuit of articulated desires and identified needs. The planning process **shall** minimally include the person, his/her guardian and his/her Individual Support Coordinator, with participation and/or input by friends, service providers, correspondents, advocates and others."
>
> *- Community Consent Decree VII.1.*

Why Do We Do Planning?

There are several reasons for doing planning:

For a good life: the plan represents the person's individual hopes, dreams, fears, needs, desires, and priorities – the things that are important for the person to have a good life. Without a plan, it is much less likely that the person's hopes and dreams will ever be realized.

To communicate to supporters what is important to the person and what supporters need to do. Over the course of a year staff may change and memory may be faulty. The written plan provides a consistent message of what we are doing and why.

To monitor progress toward achieving goals, and to revise the plan as necessary throughout the year so that we are effectively supporting the person.

To coordinate the efforts and contributions of the person and their supporters, avoiding gaps or duplications.

To be accountable for keeping our commitments to the person and to each other.

For funding: services must be identified in the plan to be reimbursable.

The personal plan is a legal document, required by law and regulations.

To demonstrate compliance with laws, regulations, court decrees, policies and procedures

Why Person-Centered Planning?

Until the 1980's, most human services were based on clinical models that sought to identify problems and plan treatment to remediate those problems. Then a few people began developing different assumptions and practices which came to be known collectively as person-centered. The chart below highlights some of the critical differences between person-centered approaches and other models.

Clinical Approach	Person-Centered Approach
• Focus on diagnosis, disability, deficit as identified through formal assessments	• Focus on the person and their individual capacities and interests. Disability is seen as one of many characteristics, not the defining characteristic of a person.
• People with similar diagnoses or deficits tend to be treated similarly	• People spend time with others who share mutual interests
• People are likely to be grouped with others who have similar diagnoses or perceived needs	• The person and their support network make decisions, seeking professional advice as needed
• Professionals make major decisions about treatment	• Find ways to discover the person's life story from family, friends and service workers. Find creative ways to tell the story and keep it fresh
• Rely on professional documentation and records	
• The person is a client of the service system, and treatment is given in service settings	• The person is a citizen and is supported to participate in community life with fellow citizens
• Practices tend to emphasize differences between the person and typical citizens	• Emphasize similarities with typical citizens
• Offer a limited range of treatment options, and try to find the best fit	• Create individual supports for each person
• Focus on quality of treatment as defined by regulations and professional standards	• Focus on quality of life as defined by the person
• Rely on professional skill, technique, technology	• Rely on relationships, support of friends, family, and neighbors as well as professionals
• Expand the service system to address more aspects of a person's life	• Organize communities to be more inclusive and accommodating
• Professional roles are strictly defined	• Roles are fluid according to what makes sense for the person
• Defines the pre-requisite skills needed to move to a less restrictive service setting	• Assume inclusion, and provide necessary support
• Services are impersonal, staff are interchangeable	• Individual relationships with service workers are recognized and respected.

Definitions

Ally: A trusted friend or supporter who helps the focus person with the planning process. Other participants, such as family members or friends, may also benefit from the support of allies.

Case Manager: A Community Case Manager (CCM) or Individual Support Coordinator (ISC)

Community Case Manager: (CCM): A Case Manager employed by a private agency under contract to DHHS to provide case management for DHHS Developmental Services

Class member: A member of the Pineland class defined in the Community Consent Decree as having been involuntarily confined at Pineland on or after July 3, 1975 or conditionally released from Pineland and in community placements on or after that date. (VI.2)

Correspondent: A person appointed by the Oversight & Advisory Board (OAB) to act as next friend of a person with intellectual disabilities or autism when no private guardian or family member is available to fill that role. (34-B MRSA §5001.1-B)

Focus person (consumer): The person who is being supported through the planning process and whose interests direct the process. When the focus person has a legal guardian, the term "focus person" is understood to include the guardian.

Generic resources: Resources that are generally available to everyone in a community, such as coffee shops, banks, hairdressers, community clubs or organizations, schools, retail stores, libraries, recreation programs, parks, hospitals. Using generic resources is one way of opening doors to the ordinary life of the community.

Guardian: Whenever there is a legal guardian, the guardian **must** be informed of, and involved in, those aspects of the planning process that are covered by guardianship. The guardian is responsible for making decisions in accord with the person's desires and best interests.

Individual Service Plan (ISP): A personal plan developed by the person and Case Manager.

Individual Support Coordinator (ISC): A case manger employed by DHHS Developmental Services

Meeting facilitator: The person who chairs and moderates a planning meeting. The focus person may choose the facilitator, and may choose to facilitate the meeting themselves.

Meeting recorder: The person who takes notes during a meeting.

Natural supports: Generic or unpaid persons or organizations that are not part of the formal social services structure. Natural supports include family, friends, neighbors, and generic resources.

Participant: Anyone who contributes ideas or activity to the process, whether they attend a planning meeting or not.

Person: Unless the context indicates another meaning, "person" refers to the focus person

Personal Plan: The Person-Centered Plan together with any other plans, e. g., health care plan, safety plan, behavior plan, etc.

Planning Process Coordinator (PPC): The person who is responsible to see that all tasks involved in the planning process are completed and monitored throughout the entire process.

Planning team: The planning process **requires**, at a minimum, the person, the guardian, the Case Manager and the OAB Correspondent, if there is one. The planning team may include members chosen by the person

Communication

There are two major areas of communication throughout the Person-Centered Planning process. The first is with the focus person; the second is communication with and among the planning team.

The Focus Person

The focus person needs to feel respected and supported in order to express themselves freely and honestly. We need to set aside our own expectations or assumptions about what we think or believe the person 'should' want. We need to listen not only to what the person tells us, but also to what it means to them.

> When asked what he likes to do Fred says, "Go fishing". Fishing means different things to different people. What does it mean to Fred? We need to understand the **when**, **where**, **how**, **with whom**, and the **why** of what fishing means for Fred. Going out on the ocean? Sitting on a dock? Walking along a stream? Going out on a lake in a boat? Ice fishing? Renting a smelt shack? Getting up early? Enjoying peaceful solitude? Being with friends? Going out for an hour at sunset? Staying out all day? Using live bait? Casting? Watching a bobber? Does Fred care if he actually catches fish or not? Does fishing mean taking along food and drink? When we understand what fishing means to Fred, we'll know better how to support him
>
> One way to learn what something means to the person is to ask "What would that look like?" Ask for more details until you have a clear 'picture' of what they mean. You can make a simple drawing to capture important details and be sure you're hearing correctly.

If there are communication barriers that make it difficult for us to understand the person, we need to be even more attentive, or listen in different ways. We need to 'listen' by observing the person's behavior – noticing when they are tense or relaxed, when they appear happy, sad, anxious, in pain, or angry. We need to 'listen' to their experience, their values and priorities. We need to try to put ourselves in their position, with their abilities and experience, and understand the world from their point of view. The Person-Centered Plan **must** include plans for addressing communication barriers. For example, a plan may require that all staff learn Darlene's gestural vocabulary, or learn to program and maintain Terry's communication device.

"No Surprises"

The second area of communication is among the planning team. In order to participate fully, everyone needs to know what to expect and what is expected of them at each step in the process. A good rule is "No surprises". The Planning Process Coordinator has a critical role to play in communicating with participants at each stage of the planning process.

The focus person needs to understand their role in the process, as well as what to expect from others at each step in the process. The focus person may also need coaching, practice, and support in order to communicate their desires and take an active role in their planning.

> ☞ The booklet "It's Your Life, What's Your Plan?" is a consumer's guide to the PCP process written in plain language. It is available in different versions with text, with graphics, or with Mayer-Johnson BoardMaker™ symbols. This booklet is available from the DHHS Developmental Services district offices.

Overview of the Planning Process

The planning process consists of five major stages:

1. **Preparation**: Understanding the person and their situation, gathering information, encouraging others who know the person to contribute their perceptions and ideas.
2. **Pre-Planning:** Working with the person/guardian to review information, set priorities, determine an agenda, and invite people to join in the planning process
3. **Action Planning:** Identifying needs and desires and developing action steps to accomplish goals. Action planning is often done in a team meeting. Action planning can also be done through a series of conversations with different people. See Section IV. Action Planning
4. **Quality Assurance:** Making sure the documentation meets standards and requirements
5. **Implementation and Monitoring:** Following through on action steps, checking progress, and revising the plan as necessary.

Each of these stages is described in more detail in the following sections of this booklet, and the stages are illustrated in the Planning Cycle flowchart in the Appendix.

Forms of Personal Planning

There are many formats for personal planning. Maine Developmental Services specifies two main formats for planning – the Person-Centered Plan and the Individual Service Plan. Person-Centered principles apply to both formats. Case Managers should be familiar with both formats and use them appropriately.

Person-Centered Plan

This format is a team process, and is appropriate for persons who receive services from different providers, or who have a number of people involved in their lives. Person-Centered Planning is the default process for the great majority of people receiving developmental services.

Individual Service Plan (ISP)

This format is generally most appropriate for people who:

A. Receive only case management or who have only occasional services, and thus do not have an extended planning team OR
B. Have declined the Person-Centered Planning process

The ISP format is generally not appropriate for persons supported by MaineCare waivers. If the ISP format is used for a person receiving waiver funding, the ISP must comply with the waiver requirements for planning.

ISPs are developed by the person/guardian and the Case Manager. The Case Manager may solicit input from other people chosen by the focus person. Documentation for an ISP is similar to the PCP, and consists of:

- The *Personal Plan Face Sheet*
- A narrative description of the services to be provided
- *Continuing Services* form
- *Need/Desire* form, if there are specific actions in addition to Continuing Services
- *Team Recommendations for Waiver Services*, if applicable.

II. Preparing for Person-Centered Planning

Preparation is the information-gathering phase of the process. This is the time to engage with the person and their supporters to explore new ways of getting to know the person and understand them more fully. A variety of strategies and exercises are included in this section and in the Appendix. There are many more strategies and tools available from the resources in the Appendix, or you can create your own.

Preparation is likely to be the most time-consuming part of the planning process. There is a lot of information to be gathered and reviewed, and there may be a number of people involved at different times with different aspects of the process. Time invested in preparation will make the rest of the planning process more efficient, more productive, and more likely to result in good things happening for the person throughout the year.

Identifying the Planning Process Coordinator (PPC)

If a person is receiving services from one or more service providers, the provider contract with DHHS specifies the responsibility regarding the planning process and the planning process coordinator.

If the contract does not specify the responsibilities regarding the planning process, the hierarchy of responsibility for PPC functions will be: the residential service provider, the community support/employment provider, and lastly the Developmental Services Individual Support Coordinator (ISC) or Community Case Manager (CCM).

Once the Planning Process Coordinator is identified, consider other people who may fill any of the roles described in "Definitions".

Schedule for Planning

These guidelines assume an annual planning process. MaineCare rules (21.04-4), statute (34-B MRSA §5470.B.2.F) and the Community Consent Decree (VII.3) require that planning be done at least annually. Preparation for the development of an annual plan usually begins at least 3 months before action planning. If plans are modified during the course of a year, all of the procedures may not need to be repeated.

Planning meetings **must** be held both prior to and subsequent to the planned movement of the person to a new residence in order to coordinate supports and services and to evaluate the person's satisfaction with the change. (Decree, VII.10.k)

☞ For persons receiving services funded by the MaineCare Community and Home-Based Services waiver, planning should be completed at least 3 months prior to the person's annual waiver reclassification so that the completed plan can accompany the application for MaineCare reclassification.

- 90 days prior to reclassification – action plan developed
- 60 days prior to reclassification – complete written plan sent to the Case Manager
- 30 days prior to reclassification – plan given to district Resource Coordinator as part of waiver reclassification packet.

Gathering Information

Good planning is based in a thorough understanding of a person's past and current circumstances, as well as their hopes, fears and wishes for the future. The Planning Process Coordinator needs to be aware of the important aspects of the focus person's life. There are many possible methods for gathering information, and many techniques for helping the focus person and members of the planning team to gain greater understanding of some aspects of the focus person's life. PPCs can exercise their flexibility and creativity in working with the focus person and team prior to a planning meeting so everyone will be prepared to participate most effectively. Some activities are described in "What's in Your Toolbox?" in the Appendix. Other resource materials listed in the Appendix contain more ideas.

The Planning Process Coordinator should make sure that other pertinent documents, such as the current PCP, current healthcare plans, crisis plans, safety plans, behavioral plans and incident reports for the past year are reviewed as part of pre-planning, and that any relevant issues are addressed in the planning process.

> ☞ Request a summary of Reportable Events for the past year and the current Services and Supports Assessment from the ISC or CCM.

The PPC should also talk with the focus person and other members of the planning team in preparation for developing the annual plan. At a minimum, make sure incident reports/reportable events for the past year are reviewed and the *Response Sheet for Essential PCP Information* is distributed to planning team members (see below).

> ☞ Start collecting and recording information on the *Personal Plan Face Sheet.* You will not be able to complete all the items on the *Face Sheet* now, but completing as much as possible will save time later.

Personal Profile

If the focus person is new to the planning process or if many of the team members don't know the person well, it is very helpful to develop a synopsis of the focus person's past and present life, as well as their hopes and fears for the future. This may be done as a narrative, or it may include photos, graphics, or even audio or video. The best profiles are created by or with the focus person. There are many ways of developing and adding to a profile, some of which may be found in the resources in the Appendix.

A personal profile is not a clinical description. A personal profile presents the focus person in positive and personal terms rather than clinically and objectively. The profile is more concerned with a person's abilities than their deficits; more concerned with the supports that enable them to succeed than with the limitations that allow them to fail. The profile looks at the person in the context of their life and their relationships, as well the person's individual characteristics.

The personal profile is a work in progress, and should be updated at least annually to reflect significant changes in the person's life. There are many ways of developing and adding to a profile, some of which may be found in the resources in the Appendix. The profile is **not** required as part of the PCP narrative. The annual update may be included as part of the narrative if desired.

☞ Doing exercises with team members that encourage them to adopt the person's point of view can be a way to gain insight into the focus person's world. This can be done by asking team members to write a short first person profile or writing a letter from the person to their supporters. See "First Person Profiles" in the Appendix.

Identify Capacities

An important part of the preparation process is to identify the person's capacities, gifts, and interests. A gift may be a skill or a personality trait. It may not seem to be a big thing – it may be an inviting smile, a sense of gentleness, a love of music, or a great laugh. Gifts, capacities and interests are what the person offers to the world, and what draw other people to the person. Gifts, capacities and interests are the basis for getting involved with other people and forming relationships.

As gifts, capacities and interests are identified, encourage the planning team to consider how they can be developed to increase the person's opportunities to have new experiences and become known to new people. See "Making the Most of Action Plans", pg. 21

Joe volunteers in a reading program with a local second grade class. Once or twice a week he visits the classroom and the children flock around, eager for a chance to read to him. It might seem that Joe is an unlikely reading assistant because he doesn't walk, doesn't talk, and is completely blind. However, one of Joe's gifts is that he likes being around youngsters, and is calm and quiet with them. As the people who support Joe thought about where a quiet man who likes young children might be welcome, someone thought of children needing to practice reading aloud, and that idea turned into a very successful partnership that benefits Joe and the second graders. Joe is a good listener. He doesn't interrupt the children or correct them as they read – he just listens, humming softly. And the second graders practice their reading every day, hoping that they will be picked to spend some time reading to Joe the next time he visits their class.

The Response Sheet for Essential PCP Information

The *Response Sheet for Essential PCP Information* **is required** as part of the planning process, unless the focus person or guardian objects. A copy of this form is in the Appendix, and on the Developmental Services web site. The *Response Sheet* is intended for use in preparation and pre-planning; it should **not** be introduced at the action planning stage.

The *Response Sheet* is intended to support consideration and communication of the full range of possible topics for planning. Sometimes it's hard to remember everything that has happened or that might happen over the course of a year, so the *Response Sheet* can be a reminder to look back and to think ahead about what might be important areas for planning.

The *Response Sheet* is a tool for stimulating ideas and ensuring that critical areas for planning are considered. Unless the focus person objects, it is to be sent to all participants prior to pre-planning with the person.

Everyone participating in the planning process (even those who cannot attend a planning meeting) can review the *Response Sheet* and submit their suggestions to the PPC. Not all areas need to be addressed for each person. If someone's life is going reasonably well, there may be only a few areas that need to be addressed. If someone's life is not going well, then there may be many areas to be addressed and prioritized.

☞ If there are family members or other team members who are not familiar with the *Response Sheet*, a cover letter or a phone call explaining the form and its intended use will be very helpful. Let them know they should only check the most important items, and that comments are much more helpful than just a check on an item. You may offer to go through the form with them in person or over the telephone to see what their concerns are.

Once the *Response Sheets* are returned, the PPC will summarize every one's suggestions on a single *Response Sheet*. Then all suggestions will be reviewed and prioritized with the person and/or guardian in setting the agenda for a planning meeting (see section III. Pre-Planning with the Focus Person). Some topics may be put on the agenda for action planning. Others may be addressed separately. Some items may not be addressed at all. Everyone invited to a planning meeting should receive an agenda ahead of time so they can be prepared to work together most effectively.

Procedure

- The *Response Sheet* is sent out to all participants 45 days prior to action planning, to be returned to the PPC within 30 days.
- The PPC summarizes the information on a separate copy of the *Response Sheet*
- The PPC and focus person/guardian review the *Response Sheet* summary (see section III, Pre-Planning) and use it to identify agenda items and other issues as appropriate.
- A copy of the summary is attached to the completed PCP which is sent to the Case Manager for review.
- The original *Response Sheets* received from participants are kept on file by the PPC for 18 months and may be audited in assessing compliance with PCP requirements.

☞ The "Workbook for Person-Centered Planning" is a companion to "It's Your Life, What's Your Plan?" It can be used with the focus person, or can be used by people who know the person to give their thoughts about different aspects of the person's life. A copy of the workbook can be placed wherever staff documentation is kept several weeks before pre-planning, so that each staff person can add their notes and ideas from time to time. The workbook is available from DHHS Developmental Services district offices.

<u>The *Personal Plan Face Sheet*</u>

Some of the information on the *Personal Plan Face Sheet* can be gathered during preparation. Researching dates and names of health care providers ahead of time will simplify the process later

Preparation Documentation

- Brief narrative description of preparation process
- *Response Sheet* summary
- Original *Response Sheets* kept by PPC for 18 months
- *Face Sheet* (as much as possible)

III. Pre-Planning with the Focus Person

Consumer Direction

Be sure the focus person understands the planning process and knows what to expect. They need to understand that the planning team is supposed to follow their lead as much as possible. Some consumers see their plan as rules or programs prescribed by others that the consumer has to follow. The booklets *It's Your Life, What's Your Plan: A Consumer Guide to Person-Centered Planning* and *A Workbook for Person-Centered Planning* may be helpful. The planning process needs to be flexible to meet the needs of the person, and to support them to engage as much as possible in the process. The focus person should understand the connection between what goes into the plan and what happens in their daily life. If they want to have something happen, it needs to be clearly stated in the plan. Consumers/guardians also need to be informed about their right to disagree with other team members. They need to know that there is a Grievance and Appeal procedure if disagreements are not resolved quickly.

Role of the Guardian

If there is a legal guardian, they **must** be informed of and involved in the pre-planning process, especially in establishing the agenda. Some guardians may prefer to let the PPC manage the process, but the guardian still needs to be informed about what's happening and give their approval. If for some reason the guardian is unable or unwilling to participate in the planning process, document the reason in the summary of pre-planning.

Role of the Correspondent

A volunteer Correspondent appointed by the C.A.B. may be someone who already knows the person, or may be introduced through an application and matching process. This is a voluntary unpaid relationship defined by the person and the Correspondent. The Correspondent has the legal right to review the person's records (XVI.5), to be informed of what's going on in the person's life, and to participate in planning or any other activity as they choose. The role of the Correspondent is what they wish to make it.

Setting an Agenda

The PPC and the focus person/guardian review the current plan, the *Response Sheet* summary, incident reports/reportable events, health information, the current, potential and unmet needs from the Services and Supports Assessment (available from the ISC/CCM), and any other information that will help set an agenda. Some people may have many activities or issues in their lives, and you will need to work together to prioritize the most important ones.

> ☞ This is also a good time to think about which items are related to each other and can be clustered together under the same agenda heading. Clustering related items on the agenda will make writing action plans easier.

If there are communication barriers, the narrative summary of the pre-planning process **must** include how these were addressed. If the communication barriers are such that the focus person has little or no direct input into the process, there **must** be a description of how team members have attempted to understand the person's needs and desires.

Sensitive Issues

There may be some aspects of the person's life that are, or should be, personal and private. The person may want information regarding these issues shared with only certain people, but not their entire planning team. They may not even want the whole planning team to be aware that there is an issue. They may have real concerns about having information on sensitive issues documented in their plan. Sensitive issues often relate to diet and weight control, hygiene, medical conditions, sexuality,

smoking, money, intimate relationships or behavior. The PPC should assist the person to consider their options for addressing sensitive issues. It can be challenging to balance someone's right to privacy with our system's need for accountability. Some considerations are:

- Who needs to know about this issue?
- How will it be addressed?
- How will it be monitored?
- How and where will it be documented?

Note that sensitive issues are identified by the person, not by the planning team or any other team member.

Some sensitive issues may be addressed as part of routine health care and be documented in the medical record. They may not need to be specifically identified in the PCP document. Others may be referred to only generally, e.g., "Marie will meet with the nurse for health information", without specifying whether it's about smoking, sexual concerns, dieting, or incontinence.

Some people have not experienced much privacy in their lives. Every aspect of their lives including their hygiene, toileting, personal and family history, and sexual behavior have always been observed, documented, and discussed publicly. As a result, they may not have developed a sense of what is and is not generally considered appropriate personal information to be shared with others. Pre-planning may be an opportunity for discussion about what information is public and what is private, and the person's right to control how information about them is shared. People should also be aware that their plan is not a private document, and that a number of people beyond their planning team will have access to it.

All team members should know what is on the agenda before meeting. It may be very important to be sure that certain team members also understand that certain topics are **not** on the agenda and will not be discussed at the planning meeting.

> Bill's sister is his guardian, and she is very concerned about him gaining weight because there is a family history of diabetes. Bill is very clear that he does not want his weight or diet discussed at his planning meeting. The PPC, Bill, and his sister need to work out a way to assure that Bill's health will be addressed while respecting his desire for privacy. This may involve a separate meeting with Bill, his sister and a doctor, nurse, or nutritionist.

Roles, Obstacles and Supports

During Pre-Planning the PPC and the focus person decide who will fill the key roles in the process (see Definitions, pg. 5).. Identify any potential obstacles and the supports that may be needed to overcome those obstacles.

- Sharon is less likely to speak up and advocate for herself if she is sitting facing her parents, so plan the seating so that she will not face them directly.
- Frank wants to facilitate his meeting, but he doesn't read and will have trouble following the agenda. Using pictures or symbols will give him an agenda he can follow and help him keep discussion on track.
- Dan's brother Greg became Dan's guardian after their mother's recent death. Greg has not been very involved in Dan's life for several years, and has never been part of the planning process. Plan how to support Greg in learning about and participating in the planning process.

- Gayle can tolerate her planning meetings for a short time, but after a while she tends to rock violently in her chair or flail her arms and scream . This disruption can be avoided if someone notices when she is becoming restless and asks if she needs a break. Gayle and her PPC ask Terry to sit beside Gayle during her planning meeting. Terry's role is to check in with Gayle whenever she becomes restless, and call for a break if one is needed.
- Rose does best when she can focus on just one topic with just one other person for up to half an hour. Changing topics is very confusing for her. Rather than addressing a number of agenda topics in one meeting, Rose will have a series of short meetings over a couple weeks, one meeting for each agenda topic. She will meet with just one person each time. Then her whole team will meet without her to draft the action plan, and one person will present the draft action plan to Rose for her feedback. This process will take longer, but it will work better for Rose and result in a better plan.

☞ Facilitating a planning meeting is a complex skill. If the facilitator is also trying to take notes, keep an eye on the time, support the focus person and participate in discussion all at once, it can become overwhelming. Delegating some tasks prior to the meeting will make it easier. However, be sure the person to whom you are delegating is capable. A timekeeper needs to watch the clock and remind the team when it's time to move on, take a break, etc. If an ally for the focus person or for another team member is needed, this should be arranged as part of pre-planning, not at the team planning meeting. The role of recorder can be complex and deserves careful thought. If you will be writing the narrative and the action plan from someone else's notes, you need to be confident of their note-taking. If the recorder will be writing the narrative and action plan, you need to be confident of their skills.

Communication

Even if a person does not speak or use a communication system, and even if their guardian is making decisions about the planning process, it's essential to involve the person in pre-planning. The PPC or someone who knows the person well should explain everything to them in whatever way they may best be able to understand. Look for reactions that indicate agreement, disagreement or confusion. Remember that the focus person drives the planning process.

☞ Some strategies for planning with people who don't talk.

- If the person uses an electronic voice output device, pre-program it with questions or statements about each agenda topic.
- Use pictures, photos, or symbols to indicate agenda topics. Photos of real persons, places, and activities are usually more useful than generic drawings or abstract symbols
- Video clips or PowerPoint slide shows can be used for a personal profile or highlights of the past year.
- Involve a communication ally whose role is solely to support the focus person in communicating.
- Some people can communicate through an interpreter. It is very helpful to use the same interpreters consistently, if at all possible. Scheduling is often difficult, so book them a year ahead for next year's planning.

☞ Some strategies for planning with people who don't talk, cont.

- Be clear about the difference between TALKING ABOUT and DOING things on the agenda. If Alicia uses pictures at home to tell when it's time to DO something, the same pictures used in preplanning or at a planning meeting could be confusing or disruptive if Alicia thinks it is time to DO instead of time to TALK ABOUT what the picture represents.
- Be sure to include pictures of what the person does NOT like or want, as well as what they do like or want. For instance, Tony likes going to the pet shop to see the birds and fish, but he hates snakes. The shortest route to the birds and fish goes right by the snake cages. Tony needs a picture of snakes to show staff that he doesn't want to go near the snakes, so they'll avoid that aisle in the store

Pre-planning provides many opportunities for problem-solving with the focus person. Many people have been passive participants in life. They have not directed or controlled their own lives; life has just happened to them. Looking at different options and making choices about their planning process can be a powerful way of learning self-advocacy. The focus person often takes great pride in pre-planning. People also participate very differently when it is clear that other participants are truly planning *with* them rather than *for* them.

Scheduling

Planning meetings should be scheduled at the convenience of the focus person, guardian, and correspondent. The focus person should not have to take time off from work or other important activity for a planning meeting. Consider whether the focus person has other daily routines that should not be interrupted, or if their energy level tends to be higher or lower at certain times of day.

It can be difficult to find a time when everyone can get together. Scheduling usually involves some compromises dictated by participants' availability. The focus person and the PPC may have to decide how to involve people who can't attend a planning meeting. Teleconference or videoconference and sharing information before and after a meeting may be useful strategies for including everyone.

Sometimes the best approach is to have more than one meeting in order to accommodate people's schedules and deal with different topics on the agenda. In the narrative, document the dates, attendance, discussion and decisions made at each meeting.

Location

The location of a planning meeting can have a powerful influence on the process. Generally settings that are familiar and comfortable for the focus person work best, such as their kitchen or living room. Some teams have met and planned over a meal. The focus person may take great pride in hosting the meeting and serving refreshments. Some prefer to meet at their worksite. Some people prefer to meet in more neutral space, such as an office. When thinking about sites, consider:

- Is the space appropriate to the number of people, neither too large nor too small?
- Is there likely to be noise or other distractions?
- Will there be sufficient privacy?
- Are the any difficulties with accessibility or parking?

Notices & Invitations

The Community Consent Decree and Maine law identify certain people who are to be invited to participate in the planning process and others who are to be notified.

- The planning process **must** include, at a minimum, the focus person, guardian, Case Manager and OAB Correspondent, if there is one. Document the reason if any of these are not participating in the planning process.
- Unless the focus person objects, the OAB Correspondent and Advocate **shall** be invited to the planning meeting. If the focus person objects to inviting the Advocate or OAB Correspondent, this should be noted in the narrative. If there is no Correspondent for a class member who has no involved family or private guardian, the need for a Correspondent should be discussed as a potential agenda item.
- The Advocate and OAB Correspondent **shall** receive notice of the planning meeting, even if not invited.
- Record who was invited and/or notified on the *Notification and Attendance* sheet.
- Designing or selecting personal invitations can contribute to a person's sense of ownership of the planning process.
- Invitations and notices should include the agenda so that everyone will be prepared to participate.

> ☞ Note that "participate in the planning process" is not the same as "attend the meeting". Key people can be involved in the process even if they are unable to attend a specific meeting.

Ask the person if they would like to invite a friend to participate in their planning. A person who receives services could be intimidated by meeting with paid staff, administrators, and other people who may be perceived as authority figures. Having a friend as peer support may help equalize the power balance of a meeting. A friend who has no other role may be able to encourage the person to speak up for themselves, and keep discussion focused on the agenda topic at hand. A friend may also remind other participants to use plain language and explain anything that is not clear to the person.

A friend may be a housemate, a co-worker, a neighbor or anyone else of the person's choice. If the friend is not familiar with the purpose and process of planning, decide how to help them be prepared to participate. If the person has no private guardian or involved family, they may request that the Oversight & Advisory Board find a volunteer correspondent who can assist them with the planning process and otherwise be available in their life.

Doing a relationship map is one way to identify significant people and relationships in the focus person's life, or to identify when significant relationships are lacking. See Relationship Maps in the Appendix, pg. 39.

Pre-Planning Documentation

- Brief narrative of pre-planning process, including the focus person's involvement
- List other people involved in pre-planning
- Indicate which information sources were or were not reviewed; e.g., reportable events, *Response Sheet for Essential PCP Information, Services and Supports Assessment*
- Document how and with whom priorities were set for the action planning agenda
- *Notification and Attendance* form
- Keep a copy of notice/invitation, including agenda, in PPC file

IV. Action Planning

Action planning is usually an annual event. Teams may also choose to meet more often, particularly if the focus person's circumstances are expected to change during the year. If it is not possible for everyone to meet at the same time, planning can be done through a series of smaller meetings, as long as there is good communication among all team members. In fact, a series of smaller meetings or conversations can sometimes set the stage for more creative planning and participation. Depending on the circumstances, action planning meetings can be very structured and formal, or may be very informal. The important thing is that the team shares a common vision and makes commitments about how to support the person to reach their goals.

Format

A general format for a planning meeting is:

- Welcome and introductions
- Review the past year, share updated profile (may use narrative, video, photos, etc)
- Review agenda and schedule
- Discuss each agenda item, identifying needs and desires
- Develop an action plan for each need/desire with persons responsible and time frames for each action
- Develop time frames for monitoring the action plan
- Develop a plan for assessing consumer satisfaction
- Review the entire plan to be sure it is complete and accurate

The Facilitator Role

The Facilitator is the person who chairs or moderates the planning meeting(s). Specific functions of this role are to see that:

- Participants are welcomed and introduced to each other
- There is a written list of those attending. If the focus person, guardian, OAB correspondent, or Case Manager did not attend, note the reason.
- Everyone understands the purpose and the schedule for the meeting
- Everyone understands the agenda
- Each agenda item is discussed
- Discussions are civil and productive
- Specific actions are identified for each need or desire
- A person is identified as responsible for each action
- A time frame is established for each action
- A person is designated responsible for monitoring medical and dental services
- A person is designated responsible for updating critical information
- The actions, persons responsible, and time frames are recorded in the action plan
- Any unmet need is identified and an interim plan is developed
- Any required documentation is done

There is a great deal of flexibility in how these functions are performed. Each planning meeting should be adapted to the participants and the circumstances, with priority on the needs of the focus person. In some cases the Planning Process Coordinator will act as meeting facilitator and recorder. In other cases these functions may be shared among two or three people.

Facilitation Skills

The role of the facilitator is to manage the process so that it goes as smoothly as possible. The facilitator guides the planning team's work, but the facilitator cannot do the team's work for them. The team is responsible for defining needs and desires and deciding what services will be provided, how, and by whom.

☞ Much of the art of good facilitation consists of asking questions such as:
- "Can someone summarize that discussion in a short statement?"
- What will that look like when it happens?"
- What does that mean to the focus person?"
- "How do we want to write that?"
- "Now, who is going to do that?"
- "Is this a need or a desire?"
- "What's a reasonable time for this action step?"

The Narrative

It is important that someone take good notes during the planning meeting so that a narrative can be written describing the important points of discussion. The narrative is also the place to explain and justify the team's actions, e.g., "Mark doesn't want to miss the family camping trip in July, so he decided not to start applying for jobs until after that." Or, "Delia's brother was unable to attend in person, so he participated in the meeting via speakerphone". The narrative, in conjunction with the action plan forms, **must** reflect the range and intensity of supports the person receives. See "Service Description" below.

The Action Plan

The action plan describes each action that will be taken to address each need or desire. The action plan **must** show the person responsible for each action, and the date by which the action is expected to be completed. The action plan consists of these forms:

- ☑ *Personal Plan Face Sheet*
- ☑ *Need/Desire*
- ☑ *Attendance and Notification*
- ☑ *Continuing Services*
- ☑ *Team Recommendations for Section 21 or 29* (if applicable)
- ☑ *Interim Plan* (if applicable)

The most recent versions of these forms are online at http://www.maine.gov/dhhs/oads/disability/ds/pcp-action-plan/forms
Versions current at the time of printing are in the Appendix

☞ Service providers and other participants can be encouraged to prepare a proposed action plan ahead of time. This will often save time. The entire team must still review the proposed actions and make modifications as necessary to coordinate services.

Needs and Desires

The planning process **must** record the needs and desires of the individual regardless of the ability of the system to address them.

A **Need** is identified by the focus person/guardian and the team as something that is ***required*** to maintain or improve the person's quality of life and that should be met within a specific time frame.

A **Desire** is anything else the person wishes to achieve, have, or obtain that is not a need.

Whether a goal is categorized as a need or desire will depend on the person's circumstances. A desire for one person may be a need for another. The team, with the focus person/guardian leading, is responsible for deciding what is identified as a need and what is identified as a desire.

All needs and desires **must** be documented, even if personnel, expertise, technology, funding or other necessary resources are not available to accomplish the goal.

> Personal desires and needs shall be recorded without respect to whether those desires are reasonably achievable or the needs are presently capable of being addressed (Decree VII; 34-B MRSA §5470-B.2.G)

It is expected that when the required resources are available to the team, most needs will be met within 90 days. Whenever the team identifies a time frame greater than 90 days, it **must** explain on the *Need/Desire* sheet why the need cannot be met within 90 days despite the availability of necessary resources. For instance, Aaron's team meets in October and sets an April time frame for completing an application for summer camp because applications are not accepted until April.

Writing Needs, Desires and Actions

Writing Needs, Desires and Actions is both a skill and an art that improves with practice and experience. Since a Need or Desire may encompass several actions, and actions may be added, dropped or modified throughout the course of the year, it's a good idea to use a fairly broad category as the Need or Desire. The domains in the *Response Sheet for Essential PCP Information* can be used as the name for the Need or Desire, or you may use whatever seems appropriate. The idea is to write the Need or Desire broadly enough that it will not need to be changed if an action under it is changed.

By the same token, Actions can also be written in general terms to allow for changes that may occur during the year. For example "Alice will make a tuna salad sandwich" is very specific. If Alice decides she'd rather have egg salad or ham and cheese, the action is no longer valid. Writing the Action as "Alice will be supported to make sandwiches of her choice" allows Alice more choice and flexibility while still staying focused on sandwiches. "Alice will be supported to prepare her own lunch according to her preferences" is even broader.

The Action steps are not intended to provide all the details that might be involved. For instance, the Action need not include a detailed teaching plan (often called a Habilitation Plan) that describes the steps for making a tuna salad sandwich with varying levels of prompts.

Actions should be written clearly enough that the people who implement them will be able to document what they do on a daily basis to fulfill the Action, and so that it is possible to tell when the Action is completed. "Darryl will improve his self-esteem" is vague. How will we know if or when his self esteem has improved? "Darryl will be supported to make positive statements about himself" is clearer. "Staff will use various strategies described in Darryl's Self-Esteem book" provides more flexibility without having to list all the strategies that might be in Darryl's book.

It is perfectly acceptable in an Action to refer to another source that contains more specific details, for example "Staff will support Tyler to become independent in taking his medications, as described in his medication independence plan." or "Sheila will have the opportunity to choose a preferred activity from her list at least twice weekly".

Making the Most of Action Plans – looking beyond the service system

One role of person-centered facilitation is to challenge the person and the team to think beyond a specific activity and beyond the service system to look for opportunities to participate in the broader community. Consultant and author John O'Brien has been studying the implementation of person-centered practices around the world for many years. He has proposed 5 essential areas to consider for building on an activity to increase the person's opportunities. They are

- **Presence:** where when, and in what context a person has access to typical people and typical places
- **Participation:** the quality, frequency, and duration of interaction with typical people
- **Respect:** building and maintaining positive images of the person and the roles they play
- **Autonomy:** the extent to which the person makes their own choices and is in control of their own life
- **Contribution:** what the person has to offer to others

These areas and some of the factors associated with each one are illustrated in "5 Ideas to Build On" in the Appendix.

If Julia is learning to cook, these might be questions to expand her opportunities beyond simply cooking at home or in a day program.

- Where do other people in the community cook together? (**Presence, Participation)**
- Is there a cooking class in adult education? (**Presence, Participation, Respect)**
- Can Julia cook for a public supper, community breakfast, a shelter or soup kitchen, local bake sale, or a church coffee hour? **(Contribution, Participation, Respect)**
- Would Julia like to host a brunch or a meal for friends or family? **(Respect, Autonomy)**
- Does Julia decide what she wants to cook? Can she choose who she wants to learn from? Is she involved in shopping? What support does she get in making decisions? How is support faded as she gains competence? (**Respect, Autonomy)**

Actively supporting community inclusion and participation has long been recommended as best practice. It is also emphasized or required in the Community Consent Decree, in Maine Law, and in MaineCare regulations. See the selected sections of these documents in the Appendix.

Unmet Needs and Interim Plans

A need (not a desire) will be identified and treated as an "unmet need" when:

a. It has not been met within the time frame set by the team, or
b. Whenever the team has determined, at any point in the process, that a resource required to meet the need is not available

Each unmet need **must** be described on the *Need/Desire* form, and an *Interim Plan* **must** be developed for providing supports and services that come as close as possible to meeting the need while the team pursues the required resources for meeting the actual identified need. The interim plan **must** identify action steps, persons responsible, and time frames. The interim plan becomes part of the Action Plan.

Some individuals or agencies may feel that identifying a need as unmet reflects poorly on them or their organization. This is not true. It is important to acknowledge the needs that are beyond our current resources. Identifying unmet needs accurately enables DHHS to compile the unmet needs statewide and make the information available to advocates and legislators through reports and budget requests.

Service Description

MaineCare rules **require** a description of each MaineCare waiver service to be provided, how services contribute to the person's health and well-being and ability to reside in a community setting, and the role and responsibility of each service provider in supporting the person's goals, including the person's goals for cultivating and strengthening personal, community, family and professional relationships. Services are identified in the *Team Recommendations for Waiver Services* form, and **must be described** through the *Need/Desire* and *Continuing Services* forms and in the narrative. The narrative should describe the service needs (e.g., staff must be within earshot 24/7 to ensure Alan's safety). The narrative or *Need/Desire* should **not** specify a staffing ratio (e.g., Beth needs 1:1 staff during waking hours), since the ratio will depend on how many other persons are served at the same time in the same location. There is a separate Service Proposal form used in the funding process to specify staffing patterns.

Continuing Services

These are any services the person is already receiving (i.e., not new) which need to be monitored by the planning team, and which are expected to be achieved without difficulty; e.g., routine medical/dental care and monitoring; critical information updates; regular religious activity; annual vacation, case management, representative payee; continuing funding source. These are recorded on the *Continuing Services* sheet.

Medical/Dental Monitor

As part of the planning process for class members, a person **must** be designated as responsible for monitoring the quality of medical and dental services. The monitor sees that the person is getting routine care and acute care as needed, and may seek a second opinion or additional consultation as needed to ensure quality health care. This is usually the residential service provider. Otherwise it is usually the Case Manager. The medical/dental monitor is recorded on the *Continuing Services* sheet. Any deviation from an annual schedule of medical/dental examinations **must** be prescribed by a physician or dentist and explained in the narrative.

Critical Information

As part of the planning process a person **must** be identified as responsible for updating critical information and informing the Case Manager of any changes. This person could be the focus person, a family member, or the residential service provider. Their name is listed on the *Continuing Services* form. Critical information is basic demographic information, including names of physicians and current medications, allergies, etc. A sample *Critical Information Sheet* is in the Appendix.

Planning Team Recommendations for Waiver Services

> ☞ We strongly recommend that all the action planning functions described above should be completed **before** completing the team recommendations forms. Good discussion and agreements about action steps will usually make it very clear which service categories are appropriate for the person. Trying to identify the service category before having the discussion and agreement on actions will only muddy the waters and waste valuable planning time.

Services funded through the MaineCare Home and Community Benefits for Members with Mental Retardation or Autism (commonly called the waiver) **must** be recommended by the planning team, using the *Planning Team Recommendations for Waiver Services* form. There are separate forms for waiver section 21 and section 29. The form reflects what the team recommends, regardless of what the person has been or is currently receiving for supports, and regardless of the availability of funding. Note that the form has only a generic description of the service category – specific details of the supports to be provided for the person **must** be described in the narrative and in the action steps.

The *Planning Team Recommendations for Waiver Services* forms are required only for services covered by the Home and Community Benefits waiver, Sections 21 and 29. The forms are not needed for services that are covered as part of the MaineCare state plan, for ICF/ID services, nor for services that are not funded by MaineCare.

MaineCare services are reimbursable only if they are recommended by the team and described in the plan. MaineCare rules also **require** that the plan include any non-MaineCare services.

Monitoring

As part of the plan, a person **must** be identified to monitor the plan on a regular basis to see that actions are being taken in accordance with their timeframes. The planning team decides the monitoring schedule. Plans are often monitored quarterly. Minor adjustments to the plan, such as changes in dates or persons responsible for individual actions, may be made as part of the monitoring process. Significant changes, such as adding or deleting Needs should be done through a team review of the plan (see section VI. Plan Review).

Consumer Satisfaction

Each plan **must** include a way of evaluating the focus person's satisfaction with:

a. The planning **process**
b. The **product –** the plan that is developed, and
c. The **progress** being made in accomplishing the goals of the plan

This plan can be as simple as "Todd will ask Gina monthly if she is satisfied with her plan."

Consumer satisfaction should be assessed as part of the regular monitoring of the plan, and as part of pre-planning the next time. If at any time a consumer is dissatisfied with their plan or with any services, they are entitled to use the *Grievance and Appeal* process (see section X., Dissemination).

Action Planning Meeting Documentation

- *Notification and Attendance* form
- *Need/Desire* form(s)
- *Interim plan* form(s) for any unmet needs
- If there are no unmet needs, a statement to that effect in the narrative
- *Continuing Service*s form
- Narrative, including agenda, discussion and description of services to be provided
- *Planning Team Recommendations for Waiver Services* form (if applicable)

V. Special Functions of Planning Teams

In addition to addressing a person's needs and desires, some laws and regulation require team approval for certain procedures. Depending on the circumstances, these team functions can be incorporated into person-centered planning, or they may be carried out separately, especially if they involve sensitive issues. In any event, the focus person/guardian must be involved as part of the team.

Safety Devices

By law (34-B MRSA §5604.14.D, D-1) the use of certain devices that limit a person's freedom of movement may require approval of the planning team, depending on the intent.

Devices that are prescribed by a qualified professional and used to achieve proper body position and balance (e.g., wedges, braces, customized molded wheelchair inserts, headrests, etc) do not require team approval.

Use of a device whose purpose is to ensure the safety of a person but which may also limit a person's movement requires a physician's order, planning team approval and review by the Three-Person Committee. Examples would include wheelchair seatbelts or foot straps, helmets, arm splints, etc. Note that the determining factor is not the device per se, but the purpose of its use. The same device could be used as a body support, as a safety device, or as a form of restraint. The team is responsible for determining the intent and describing the use of the device. Unapproved use of a device may be a reportable event. For more details, go to

http://www.maine.gov/dhhs/oads/disability/ds/threeperson/home.htm

Behavioral Programs

Planning teams have explicit responsibilities in determining the need for and approving the use of programs that may infringe on a person's rights or limit their freedom of movement. These are described in the Regulations Governing Emergency Interventions and Behavioral Treatment for People with Mental Retardation and/or Autism:

http://www.maine.gov/dhhs/oads/disability/ds/threeperson/home.htm

Medical Add-On for waiver services

The Medical Add-On is a time-limited adjustment to waiver reimbursement rates that can be requested under certain conditions. The planning team **must** determine if and how a physician's recommended treatment can be implemented, and document this determination in the personal plan or in an amendment to the plan.

Add-On requirements and procedures are described in the MaineCare rules in the Appendices to Sections 21 and 29:
http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s021.doc

Individual Support Team (IST) see Section VI. Review

Limiting a Person's Rights

Each person receiving developmental services is entitled by law to all the rights of a citizen of Maine and of the United States unless some of those rights have been limited by legal guardianship or other court proceedings. In addition to the requirements listed above, any plans which limit a person's rights must have the consent of the person or guardian or be specified by a court (e.g., as conditions of probation). An agency Human Rights Committee, and the Disability Rights Center may provide valuable assistance in considering options for safeguarding a person's rights.

VI. Plan Review

A Review is not the same are regular monitoring of the plan. A review is a process by which the team (not just the plan monitor) makes significant changes in the plan. If the plan is not proceeding according to schedule, or if the focus person's circumstances change, the plan may be reviewed in order to make necessary changes. Significant changes would include addition of new needs or desires. Changes in Actions are not considered a review.

> "Events which **shall** lead to a plan review shall include, but are not lim ited to, use of crisis intervention services, use of physical restraint, and events which could lead to the loss of a person's home, job or pr ogram. Other events which **shall** lead to a plan revie w shall be iden tified by the planning team." (Decree VII.4.c,d); 34-B MRSA §5470-B.4.B)
>
> Any review process **shall** include the fo cus person/guardian and the Individual Support Coordinator. Unl ess the person has no guardian and objects, the person's Correspondent and Advocate **shall** be notifi ed of the review (Decree VII. 4.b; 34-B MRSA 5470-B.4.A)
>
> The review **shall** be done b y meeting together or by other means sufficient to address the needed or desired changes. (Decr ee VII.4.a; 34-B MRSA 5470-B.4.A)
>
> Any member of the planning team may initiate a review (34-B MRSA §5470.B.4.A; Decree VII.4))

Planning meetings **must** be held both prior to and subsequent to the planned movement of the person to a new residence in order to coor dinate supports and services and to evaluate the person' s satisfaction with the change. (Decree, VII.10.k)

If a new n eed is identified, the team **must** meet and define actions to address it. The dis cussion should be su mmarized in a narrative, and the actions defined on the *Need/Desire* form. The Case Manager updates EIS Services and Supports. There is no *Face Sheet*.

If there is an unm et need, there **must** be an *Interim Plan* and a *Face Sheet*. The Case Manager updates EIS Services and Supports.

The action plan and narrative are shared among team members.

The Review does not undergo the District QA process.

Individual Support Team (IST)
If the Developmental Services Crisis Team has become involved in a situation, an *Individual Support Team (IST)* will be convened and a cri sis intervention plan will be developed. The IST is essentially the planning team with the addition of DHHS Crisis staff and whoever else may be appropriate to the situation. The crisis intervention plan describes steps to resolve the i mmediate situation as well as strategies for preventing future occurrences. The IST will also consider the need for specific tr aining and how it will be provided. Details are available at:
http://www.maine.gov/dhhs/oads/disability/ds/comm-cm/CM_Manual/ist.html

Review Documentation

- Attendance
- Brief narrative stating reason for review and summary of discussion
- Revised or amended *Need/Desire* forms and/or
- *Face Sheet* and *Interim Plan*(s)

VII. Documentation

The complete Person-Centered Planning document contains the following:

- *Personal Plan Face Sheet*
- Narrative summary of preparation and preplanning activities
- The summary of the *Response Sheet for Essential PCP Information*
- Narrative summary of the action planning process
- The *Notification and Attendance* form
- *Need/Desire* form(s)
- *Interim plan*(s) for any unmet needs
- *Continuing Services* form(s)
- *Planning Team Recommendations for Waiver Services Section 21* or *29* (if applicable)

The complete written plan **must** be sent to the DHHS District Office within 30 days of the action planning date and at least 60 days prior to the MaineCare waiver reclassification date, if applicable.

Preparation and Preplanning Summary

- There is a narrative summarizing the preparation and preplanning process, including how the focus person was involved in the process. Include a statement of how and with whom priorities were set for the planning meeting agenda.
- If the focus person, guardian, OAB Correspondent or Case Manager did not participate, indicate why.
- If there are communication barriers, the narrative summary of the pre-planning process **must** include how these were addressed. If the communication barriers are such that the focus person has little or no direct input into the process, there **must** be a description of how team members have attempted to understand the person's needs and desires.
- If the Advocate or OAB Correspondent was not invited, indicate the reason. Note that the Advocate and OAB Correspondent are always notified, even if not invited.
- If the person/guardian declined use of the *Response Sheet for Essential Information*, include a statement to that effect.
- Include a statement as to whether Reportable Events for the past year were reviewed and, if not, why not.
- Indicate if the person identified sensitive issues or other matters to be addressed through other means, and where information can be found regarding those issues.

Action Planning Process Summary

There is a narrative summary of the action planning process that includes:

- Attendance at each planning meeting. If the focus person, guardian, OAB Correspondent or Individual Support Coordinator did not participate, indicate why. Attendance is also recorded on the *Notification and Attendance* form
- Agenda topics and main points of discussion regarding each topic
- Descriptions of services and explanations or justifications for decisions or actions that are not self-explanatory or are not adequately explained on the *Need/Desire* forms.
- A plan for assessing consumer satisfaction

Action Plans

The Action plan is written on standard forms provided by DHHS. The Action Plan consists of the *Face Sheet, Need/Desire, Interim Plan, Continuing Services* forms and the *Team Recommendations for Section 21* or *29* forms (if applicable). . The Action Plan identifies:

- Specific actions to address each need or desire identified
- A person responsible for each action
- A time frame for each action
- An *Interim Plan* for each unmet need

Continuing Services

- The person responsible for monitoring the quality of medical/dental services
- The person responsible for updating critical information

- The person responsible for regular monitoring of the plan
- Any other Continuing Services

For Class Members, the ISC adds:

- The *PCP Data Collection Form*
- Updated EIS Supports and Services Assessment
- *Request for Revision* form (if needed)

If needed, the following will be added during the year:

- Amendments to the plan

If there is a plan review during the year:

- *Face Sheet* (identifying information only)
- Narrative, *Notification and Attendance* and revised *Need/Desire*
- *Interim Plan* for any unmet needs

> ☞ Before submitting the written plan to the Case Manager, ask someone who was not involved in the planning to read it over. They will often catch omissions or incongruities that you might miss because you were so involved in the process. This can save making revisions later.

Ongoing Service documentation

Once the plan is written, each service provider **must** document when and how services are delivered throughout the year in accordance with the plan. Without such documentation as proof of service delivery, services may not be reimbursable.

VIII. Approval by the Person/Guardian

Once the plan has been written, a copy is given to the person/guardian, along with the *Personal Plan Approval* letter. The approval letter is to be returned to the Planning Coordinator within 10 days. If it is not returned on time, approval may be given by a monitored and documented telephone call. An e-mail indicating approval is not acceptable.

If the person/guardian has not indicated approval or disapproval before the 30-day deadline for submitting the plan to the DHHS District Office, submit the plan along with a note describing what reasonable attempts have been made to obtain approval.

If the ISC is the guardian, send the written plan with the Approval letter to the ISC for signature. The ISC should return a copy of the signed Approval letter.

IX. Quality Assurance and Monitoring

Person-Centered Planning is a major element in the Community Consent Decree and in the statutes governing DHHS Developmental Services. The planning process and the plans developed for individual class members are under close scrutiny by DHHS, by the Oversight Advisory Board, and by the Court Master for the Federal Court. Plans are also an essential component of MaineCare funding, and may be audited to ensure compliance with state and federal Medicaid rules. Quality Assurance mechanisms have been developed to ensure the quality of the planning process and the outcomes that are achieved.

DHHS Data Systems

Procedural steps in the planning process are tracked in DHHS data systems. This allows DHHS to report to the court on such things as patterns of attendance at planning meetings, compliance with time frames for producing and approving the written plan and time frames for meeting needs. The data also allows DHHS to monitor trends in unmet needs, identify barriers to meeting needs, and report to the Commissioner of DHHS, the Governor, and to the Legislature and request funding to meet the unmet needs.

The PCP Data Collection Form

DHHS uses a comprehensive checklist and quality assurance review process to ensure that all required elements of the planning process have occurred and are adequately documented. Note that the data collection form is completed by the ISC and is **required** for class members. Being familiar with the items in the data collection form can help PPCs and Case Managers be sure their plans are complete and will meet all the requirements. The ISC may request revisions of the plan in order to satisfy these requirements. The current version of this form and the protocol for its use are available at http://www.maine.gov/dhhs/oads/disability/ds/pcp-action-plan/forms.html. It is mandatory that all Individual Support Coordinators, ISC Supervisors and district review teams receive training on completing the *PCP Data Collection Form* from the district Quality Assurance Coordinator.

District Review

Each DHHS Developmental Services district office has a process for reviewing the plans written for Class Members in order to ensure that all requirements of the Community Consent Decree are met. If the ISC or another member of the district review team requests revisions to a plan, the request should be clear as to what change is required and why. If you are not sure what is being requested or why, ask for clarification.

Monitoring

Developing a plan that thoughtfully and sufficiently addresses a person's needs and desires is a significant accomplishment. Still, a plan is only a blueprint; it is not a house. The plan must be carried out in order to have any effect. The person responsible for monitoring the plan checks with the persons responsible for each action in the plan to see that it is being carried out according to schedule. Minor changes, such as changes in persons responsible for individual actions or reasonable adjustments in dates may be made during the monitoring process. If the monitor discovers a need for significant changes, the plan must be reviewed as in section VI.

Case Managers shall maintain at least monthly contact with each person in order to ensure that the quality and availability of services and consumer satisfaction are maintained at a high level. (34-B MRSA §5201.6.B.(1))

Consumer Satisfaction

Monitoring includes ongoing assessment of consumer satisfaction with the process, product and process as outlined in Section IV Action Planning.

Quality Assurance Documentation

- *PCP Data Collection form* (ISC)
- Request for Revision form (if needed)
- Amendment (if needed)
- Updated EIS Services and Supports (ISC/CCM)
- Monitoring notes kept in agency records

X. Dissemination

Once the Person-Centered Plan has been reviewed and approved at the District Office, it is returned to the PPC who will distribute the plan along with the *Developmental Services Grievance & Appeal insert* to the focus person/guardian. The plan is also distributed to the members of the planning team and anyone else the consumer and/or the guardian specifies.

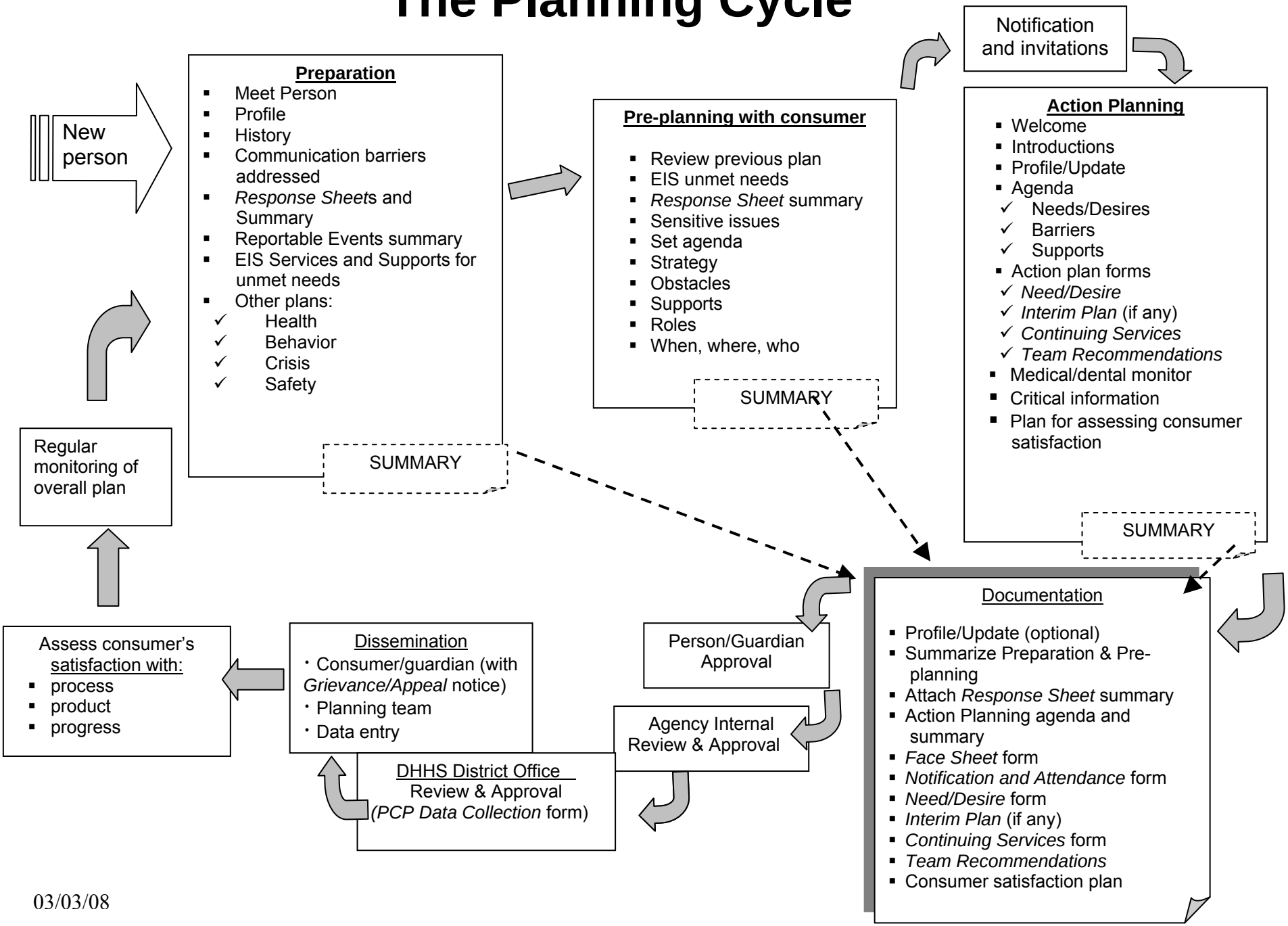
If the ISC distributes the approved plan from the district office, the ISC will distribute the plan along with the *Developmental Services Grievance & Appeal insert* to the individual, and distribute copies of the plan to the other members of the planning team and to anyone else the consumer/guardian specifies.

Developmental Services Grievance and Appeal inserts are available from the DHHS Developmental Services district offices.

XII. APPENDIX

PCP forms and instructions are revised from time to time. For the most recent version go to:
http://www.maine.gov/dhhs/oads/disability/ds/pcp-action-plan/forms.html

The Planning Cycle



WHAT'S IN YOUR TOOLBOX?

The exercises described here can be done as part of preparation for planning with the focus person or with their supporters. Some work best with a small group, such as in a staff meeting. Others can be done with individuals, sometimes in a short conversation.

Stop/Start

Make a list of what we know doesn't work and we should STOP doing with this person. Make another list of what we should START or continue that will be more effective in supporting the person.

TREASURE OR /TRASH?

Similar to STOP/START. Make lists of what is most helpful (Treasures) and what is least helpful (Trash) in supporting the person.

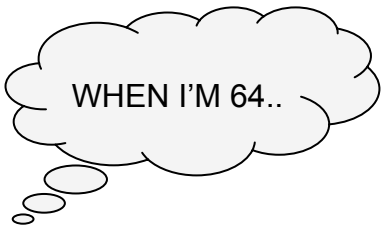
If I were King/Queen …..

If I had a magic wand….

If the person had unlimited power to change anything in their life, what would they change, how, and why? What would happen if these changes actually happened?

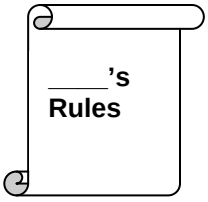
STAR QUALITY

Especially helpful when supporters are feeling negative. Simply ask what people respect/like/admire about the person. If they offer only negative comments such as "She's stubborn", or "He's manipulative", remind them that this exercise is about positive qualities. "She's stubborn" can be re-stated as "She's determined" or "She knows her own mind". "He's manipulative" can be re-stated as "He is good at getting what he wants".



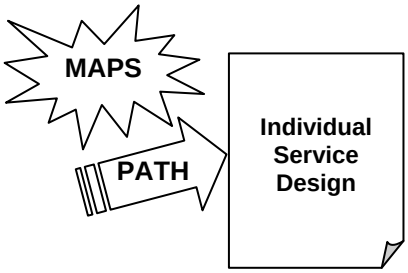
An annual planning process only looks one year into the future. What is the longer view? What might this person's life look like when they are 45, 64, 80, etc? Where will they be? What will they be doing? Who will be with them? Encourage people to give lots of details to create a full picture.

Write a summary of the person's skills and experience (paid or unpaid). Be creative in looking for positive 'marketable' qualities. The goal is not to create a resume in order to find a job, but to reflect the person's skills and accomplishments

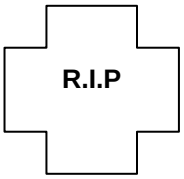


From the person's point of view, what are the rules by which the world seems to operate? For example, *"Whenever I want to go out for a walk, staff say they have to do their paperwork."*

What would be the person's rules for how the world *should* operate? For example *"Wait until I finish each sentence, even if it takes longer and you already think you know what I'm going to say."*



These are formats for in-depth discussions that provide insight and set long-term directions. They are described briefly in "Finding A Way Toward Everyday Lives" in A Little Book About Person-Centered Planning (O'Brien and O'Brien, eds. Inclusion Press 1998), . More information on MAPS and PATH can be found at www.inclusion.com.



Write an obituary summarizing the person's life, accomplishments and relationships. This can reflect the person's actual life, as well as an exercise in creating a vision of a more positive future for the person.

A video, DVD or PowerPoint of the person's life or of highlights of the past year can be a powerful presentation. This can also be an excellent way to introduce a person to new people.

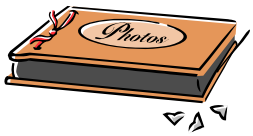
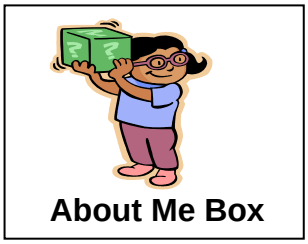


Photo albums or scrapbooks can also present the person's life story through pictures, clippings, etc.



An About Me Box contains objects or pictures that represent a person's life and interests. The box itself may reflect an interest, e.g., a birdhouse, a box from a favorite store or favorite flavor of ice cream. The items in the box can be used to prompt the person to talk about their interests when being introduced to new people. If the person doesn't talk, the box can prompt the person they are meeting to ask questions.

Create your own tools!

Relationship Maps

A relationship map is a graphic representation of the people in the person's life, their relationship to the person, and patterns of relationships. It can help us consider such questions as, Does the person have close friends? Are most of their relationships with people within the service system? How have their relationships changed over time?

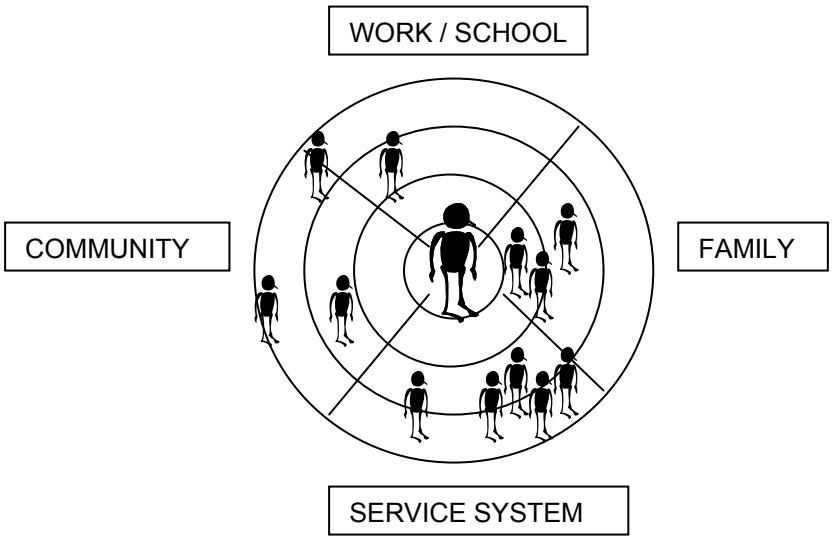
The person is in the central circle, represented by their name, a drawing, or a photo. Intimate family or friends share the central circle. The three larger circles are used respectively for:

Friendship: People who have a close, but not intimate relationship

Association: People who share a common activity, but their relationship is limited to that activity or location e.g., co-workers or classmates the person doesn't see or talk to outside of work or school, fellow members of a club, church or other organization.

Exchange: Relationships with a business or professional basis, e.g. physician, teacher, hairdresser, and support workers.

Note that a person may have a closer relationship with someone who would otherwise be in the circle of exchange or association. A co-worker may become a close friend or a boy/girlfriend. A support worker may also have a close and important relationship.



We can create maps of the past and the future as well as the present. This is a good way to look at how relationships are gained and lost over time. Who used to be involved with Sharon before her health declined? What relationships may be lost when Justin moves to another part of town, or changes jobs? Changes in relationships over time can also be represented by arrows or by moving people closer or further away.

Color coding and additional graphics can enrich the map. A difficult relationship may be indicated by a red circle around the person. Someone who has died or moved away may be indicated by a cloud outlining them.

For more ideas about how to use relationship maps, see Making Futures Happen, listed in the Resources section.

First Person Profiles

When thinking about what's important or what could be possible in someone's life, it is often very helpful not just to think about the person, but to try to think as if you were the person. Instead of thinking "This is what I know about Susan", try thinking, "I am Susan. This is what my life has been up to the present. This is what my life is now. This is what my life might become. This is what I want people to understand about me."

It is very helpful to make notes of your thoughts from Susan's perspective. Some people have written a brief autobiography – "My Name is Susan" – a short poem, a letter from Susan to her staff, or used graphics to represent some aspect of being Susan.

Explore your past as Susan in some depth. What were the best times and worst times in your life? Who were important people and significant events, both positive and negative? What has helped you? What got in your way? What have people not been able to understand or to help with effectively?

Think about the present in the same way. This may not be a comfortable experience, especially if you are very involved in the person's life, but absolute honesty is essential. What's good about being Susan right now? What's hard? What do you wish people around you would never say or do again?

Use your thinking about the past and present to think about the future. What would I want to be different than it is now? What would I want to keep the same?

We all have goals and fantasies, and sometimes only time will tell which is which. What is the wish or the dream that needs to be kept alive, even if it seems impossible?

This kind of first person thinking can be very helpful when using planning tools such as relationship maps, timelines, photo albums or any of the personal profile formats.

Of course it is impossible to know exactly another person's thoughts, emotions, or experiences. The point of this exercise is to make the effort to understand another person more deeply. It can be very useful for several people to each do a "My Name is Susan" and share their profiles with each other, because each person is likely to have slightly different perceptions about different aspects of Susan. If people have different perceptions, it's not that someone is right and someone else is wrong – it's that different people see things differently. Exploring these different perceptions by asking "What do you see or hear that leads you to believe Susan would say this?" can often lead to new insights.

A note of caution: in doing this exercise, the real Susan should not participate. If Susan is present her presence is more likely to inhibit than to inspire reflection and honest sharing. People will naturally look to her to verify what each person says, and the session will become about whose perceptions are most nearly right. People will also hesitate to say some things in Susan's presence, and those may be the very things it is important to think about and talk about.

Once there has been discussion, the group may create a profile that they feel best reflects the person, and this version can be shared with the person for their response. It can be very gratifying for the person to hear their supporters' perceptions. It may also be an opportunity to correct some misperceptions.

Timeline

A timeline is a graphical representation of a person's life. It consists of a line which is marked at appropriate points to indicate significant events. Each point has a label or a brief description of the event. Symbols or icons may be used as well as labels. Events which continue for some period may be marked by arrows or underlining. It is often helpful to include the person's age at each point.

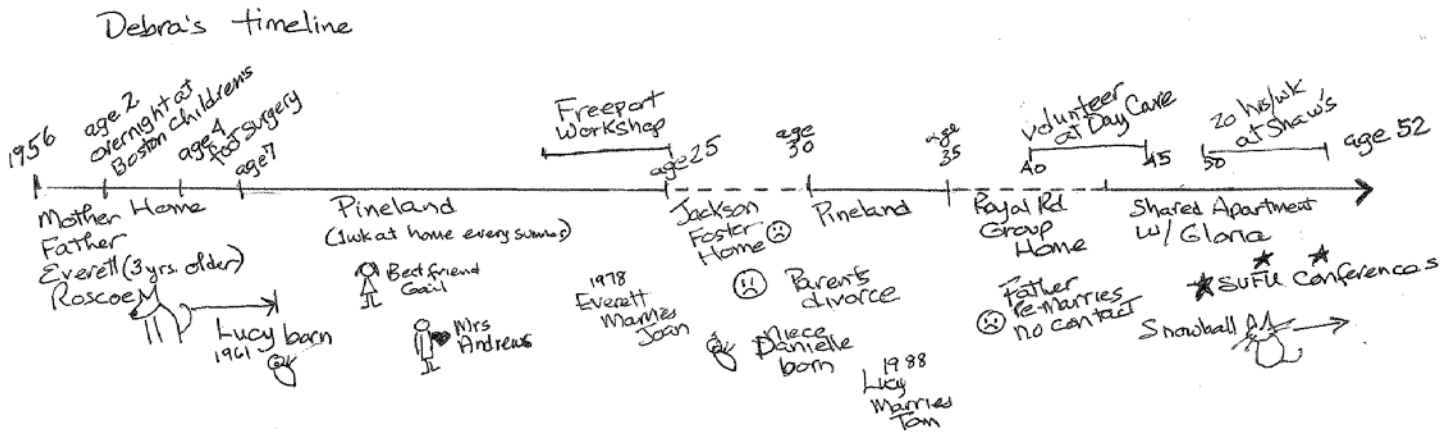
Events recorded on a timeline typically include:

Birth	Significant people (good or bad)	Graduations
Education	Births/deaths	Celebrations
Work experiences	Hospitalization	Pets
Residence(s)	Injuries	Vacations
Family members	Traumas	Special events

Anything else that the person or others identify as significant

Obviously, some sensitivity may be required as to how some events are to be captured, especially traumatic or otherwise distressing events.

Color coding may be very helpful in clarifying the information represented. For instance, if a person has lived in a number of different places, use alternating colors for each place. If the person returned to an institution several times for extended periods, highlight the institution in a different color.



5 IDEAS TO BUILD ON

Adapted from John O'Brien, 1997

PARTICIPATION

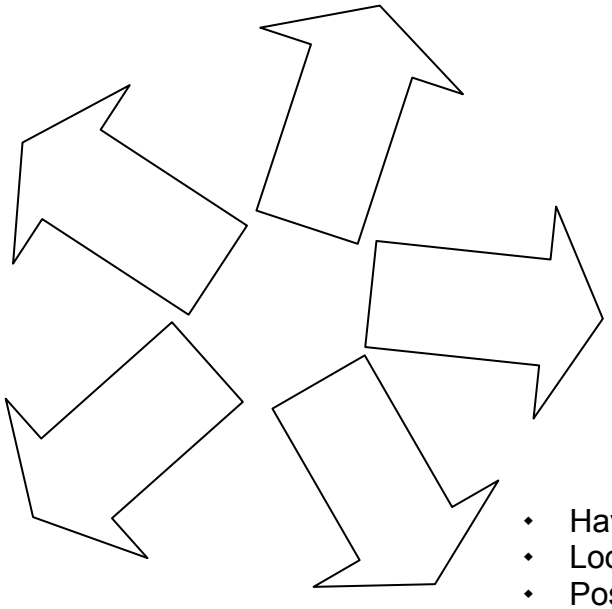
- Getting to know people
- Becoming known to people
- Belonging
- Being welcomed
- Being part of things
- Having a part to play

Some firefighters get to know Joe. Joe offers to help clean up after the supper

PRESENCE

- Being in ordinary places at ordinary times with ordinary people
- Trying a variety of places
- Being a regular at the times and places you choose

Joe goes regularly to public bean suppers at the fire station



CONTRIBUTION

- Discovering gifts, capacities and interests
- Learning new things
- Good teachers
- Building competence
- Making Adaptations
- Being needed
- Being part of something beyond yourself

The firefighters appreciate Joe's help. They show him how to run the dishwasher

AUTONOMY

- Being informed
- Knowing options
- Getting good advice
- Making choices
- Having control
- Speaking up
- Being listened to
- Mobility
- Security

Joe is in charge of the dishwasher

RESPECT

- Having positive roles
- Looking good
- Positive stories
- Positive surroundings
- Associating with respected people

Joe is accepted as a Firefighter, and rides on the truck in the parade.

Sample cover letter for Response Sheet for Essential Information

Dear _____,

(Person) is hosting *(his/her)* Person-Centered Planning meeting on *(month/day/year)* at *(time)* at *(location)*. To help us prepare for the planning meeting, we are asking selected people to complete the enclosed Response Sheet for Essential PCP Information. The information that you provide will be most helpful to *(person)* and to the planning process as a whole.

Look over the Response Sheet, check any items that you feel should be considered in *(person's)* plan, and write a brief note indicating why you think it is important. Indicate what you think needs to be covered during the planning as well as what you think *(person)* might want in *(his/her)* plan. Your response will be compiled with those from other people and reviewed with *(person and/or guardian)* in order to create the agenda for the planning meeting.

The information you share with us is important, and I look forward to receiving a completed response sheet from you as soon as possible. I have enclosed a stamped self-addressed envelope for you to return the Response Sheet. My mailing address is also on the last page of the response sheet.

Please call me at *(phone number)* if you have any questions or want to talk about the planning process.

Sincerely,

Planning Coordinator

Response Sheet for Essential PCP Information

Consumer's Name: _____ **Provider:** _____

Prepared by: _____ **Date:** _____

For PPC use in summary only

PCP Facilitator Name: _____

Total number of essential forms that the below information represents: _____

List the person(s) who submitted this form: _____

_____

_____

Please check all the elements you feel should be included in the plan. If "Other", please specify.

A. Case Management

- ☐ Case Management
- ☐ Family support
- ☐ Other

Comments:

B. Communication

- ☐ Evaluation
- ☐ Training for staff and support persons
- ☐ Behavior as communication
- ☐ Behavioral components
- ☐ Facilitated communication
- ☐ Picture exchange programs
- ☐ Primary language other than English
- ☐ Sign language
- ☐ Visual-gesture communication
- ☐ Total communication environment
- ☐ Dictionary of communicative intent
- ☐ Manual communication backup
- ☐ Other

Comments:

C. Community Activities

- ☐ Meeting friends
- ☐ Including friends
- ☐ Leisure activities
- ☐ Recreation
- ☐ Social opportunities/events
- ☐ Vacation
- ☐ Classes/educational experiences
- ☐ Natural supports
- ☐ Volunteer opportunities
- ☐ Church/other places of worship
- ☐ Clubs & other social civic organizations
- ☐ Other

Comments:

D. Day/Evening Services

- ☐ Center based day program
- ☐ Community based day program
- ☐ Home based day program
- ☐ Retirement day program
- ☐ Efforts toward employability
- ☐ Adult Education/Other classes
- ☐ Literacy
- ☐ Volunteer opportunities
- ☐ Other

Comments:

E. Education

- ☐ Private School
- ☐ Public School
- ☐ Graduation/or Date leaving school _____
- ☐ Transition Plan
- ☐ Other

Comments:

F. Environmental Modification/Adaptive Equipment

- ☐ Any piece of equipment that will enhance activities of daily living.
- ☐ Communication board
- ☐ Environmental modifications or special accommodations
- ☐ Special glasses
- ☐ Adaptive equipment/technology
- ☐ Communication equipment or resources
- ☐ Equipment repairs and upgrades
- ☐ Interim plan for times electronic equipment is down
- ☐ Other

Comments:

G. Evaluation and Treatment Services

- ☐ Crisis services
- ☐ Medical
- ☐ Physical
- ☐ Specialized medical services/home health
- ☐ Dental
- ☐ Hearing
- ☐ Therapies (occupational therapy, physical therapy, speech therapy)
- ☐ Counseling
- ☐ Behavioral (assessment/plan)
- ☐ Medications
- ☐ Nutrition
- ☐ Psychiatric
- ☐ Psychological
- ☐ Vision
- ☐ Durable medical equipment
- ☐ Safety and positioning devices
- ☐ Other

Comments:

H. Financial

- ☐ Adequacy of personal financial resources
- ☐ Agency budget constraints
- ☐ Agency financial resources
- ☐ Money management
- ☐ Representative payee
- ☐ Accessing federal/state/local assistance programs
- ☐ Contingency funds
- ☐ Family support funds
- ☐ Mortuary trust
- ☐ Other financial resources
- ☐ Personal spending money
- ☐ IRWE (impairment related work expenses
- ☐ PASS (plan for achieving self-support)
- ☐ Similar programs
- ☐ Other

Comments:

I. Legal/Regulatory

- ☐ Advanced directives
- ☐ DNR (do not resuscitate) order
- ☐ Knowledge of rights
- ☐ Power of Attorney (POA)
- ☐ Responsibility
- ☐ Behavior plan and approval process
- ☐ Law enforcement involvement
- ☐ Restraints
- ☐ Restrictions
- ☐ Violation of rights
- ☐ Evaluation for guardianship determination
- ☐ Guardianship
- ☐ Pending grievances or unresolved issues
- ☐ Other

Comments:

J. Personal Supports

- ☐ Family
- ☐ Friends
- ☐ Correspondent
- ☐ Involvement with unpaid support
- ☐ Natural supports
- ☐ Neighbors
- ☐ Clothing
- ☐ Pets
- ☐ Making decisions and choices (clothing, food, recreation, etc.)
- ☐ Sexuality
- ☐ Spirituality
- ☐ Consumer wishes/dreams
- ☐ Funeral planning
- ☐ Self advocacy
- ☐ Vacation
- ☐ Voting
- ☐ Other

Comments:

K. Residential

- ☐ Expertise of staff
- ☐ Special staffing requirements
- ☐ Staffing/supervision
- ☐ Household safety
- ☐ Need for adaptive equipment
- ☐ Provision of services as budgeted/planned
- ☐ Cleanliness
- ☐ Compatibility of house mates
- ☐ DHS care plan
- ☐ Harmony of environment
- ☐ Personal living space
- ☐ Respite
- ☐ Other

Comments:

L. Safety

- ☐ Medical administration
- ☐ Training for self-administration
- ☐ Personal identification
- ☐ Personal safety
- ☐ Special supervision needs
- ☐ Access to emergency assistance
- ☐ Emergency evacuation
- ☐ Emergency information
- ☐ Screenings/immunizations
- ☐ Safety
- ☐ Safety accommodations
- ☐ Street/community
- ☐ Vulnerability to victimization
- ☐ Other

Comments:

M. Skill Building

- ☐ Accessing community services
- ☐ Toward more independence/self advocacy
- ☐ Other

Comments:

N. Surrogate

☐ Decision making ☐ Guardianship ☐ Other

Comments:

O. Transportation

☐ Community activities
☐ Program services
☐ To work
☐ Wheelchair safety
☐ Church
☐ Recreation
☐ Visiting family/friends
☐ For using transportation safely
☐ Independent use of transportation
☐ Other

Comments:

P. Work

☐ Job assessment
☐ Vocational rehabilitation referral
☐ Enclave
☐ Job in the community with/without job coaching
☐ Sheltered employment
☐ Pay/rate of pay
☐ Real work for real pay in integrated setting
☐ Relationships with co-workers
☐ Other

Comments:

Please return by: (Insert Return Date)

To:
(Insert Name)
(Insert PHONE # _____
FAX: # _____
Insert E-Mail: _____)

(Insert Address)

Mark your calendar now. PCP is scheduled for:

Date:

Time:

Location:

Adult Developmental Services
Personal Plan Face Sheet

Identifiers

Consumer name		**Region:**
MaineCare ID #		**__ 1 __ 2A __ 3B**
EIS ID #		**__ 2T __ 3P**
ISC/CCM name		**__ 2L**

Facilitator

Name of person writing this plan	
Organization	

Plan

Plan start date	___/___/
Plan end date	___/___/___.

Plan Type __ Annual __Review/Other __ Interim

***Next Waiver reclassification date** ___/____/____ OR ____ no waiver

***Pre-Planning**

Preplanning start date ___/___/___. (see narrative)
Response Sheet Summary used in Pre-Planning with consumer/guardian ___ Yes ___ No
Reportable Events reviewed? ____Yes ____ No __ No Reportable Events
IST in past 12 months? ___ Yes ____No

***Routine Health**

Date of most recent:	
Physical exam	___/___/___.
Dental/oral exam	___/___/___.
IV sedation for dental/oral procedure? __Y __ N	___/___/___.
Vision exam (if needed)	___/___/___.
Hearing exam (if needed)	___/___/___.
Psychotropic meds __ Y __ N Reviews 1. By psychiatrist? __ Y __ N 2. By psychiatrist? __ Y __ N	 ___/___/___. ___/___/___.
Mortuary Trust (age 50+ only)__ Yes __ No	

Current Medical Providers	
Name	**Specialty**

Planning Coordinator signature _____ Date ___/___/___.

Action Plan (To be completed by ISC/CCM)

Unmet needs are identified? ___Yes (see narrative) __ No unmet needs
Plan for assessing consumer satisfaction? __ Yes __ No
Planning team monitoring schedule:

This plan accurately reflects the planning process and the person's needs and desires. The recommended services are medically necessary and in compliance with MaineCare rules

ISC/CCM Signature _____ Date___/___/___.

* these items are required for the annual plan only Revised 11/27/07

Notification and Attendance

Relationship	Name (*please print)*	Check all that apply
Consumer		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Guardian		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Co-Guardian		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
ISC/CCM		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
OAB Correspondent		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Advocate		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Family __ Provider __ Other __		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Family __ Provider __ Other __		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Family __ Provider __ Other __		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Family __ Provider __ Other __		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Family __ Provider __ Other __		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Family __ Provider __ Other __		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Family __ Provider __ Other __		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Family __ Provider __ Other __		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other
Family __ Provider __ Other __		__ Pre-planning packet __ Notification __ Invitation Attended meeting: __ In Person __ Via phone or other

Page __ of __

DESIRE/NEED AS DETERMINED BY TEAM

#	NAME OF DESIRE/NEED:	
DESIRE/NEED DESCRIPTION: ☐ *Projected date exceeds 90 days because:*		
START DATE: _ _/_ _/_ _	PROJECTED DATE: _ _/_ _/_ _	☐ DESIRE ☐ NEED ☐ UNMET
PERSON RESPONSIBLE:		
REASON: ☐ Continuing ☐ New	LONG TERM GOALS FLAG: ☐	

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE: _ _/_ _/_ _	TARGET DATE: _ _/_ _/_ _	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE: _ _/_ _/_ _	TARGET DATE: _ _/_ _/_ _	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE: _ _/_ _/_ _	TARGET DATE: _ _/_ _/_ _	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE: _ _/_ _/_ _	TARGET DATE: _ _/_ _/_ _	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

page _____ of _____ Revised 8/16/05

INTERIM PLAN

#	***INTERIM***	
NEED DESCRIPTION:		
START DATE: _ _/_ _/_ _	PROJECTED DATE: _ _/_ _/_ _	
PERSON RESPONSIBLE:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE: _ _/_ _/_ _	TARGET DATE: _ _/_ _/_ _	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE: _ _/_ _/_ _	TARGET DATE: _ _/_ _/_ _	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE: _ _/_ _/_ _	TARGET DATE: _ _/_ _/_ _	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

page _____ of _____ Revised 06/26/03

CONTINUING SERVICES

CONTINUING SERVICE	ASSIGNED TO	TARGET DATE
Case Management		_ _/ _ _/ _ _
Representative Payee		_ _/ _ _/ _ _
Medical/Dental Monitor		_ _/ _ _/ _ _
Critical Information updates to ISC/CCM at least monthly or as changes occur		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _
		_ _/ _ _/ _ _

Team Recommendation of Supports Waiver Services (Section 29)

The planning team recommends the following service categories. See plan narrative for details

____ **Community Support** is Direct Support provided in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and limited support in areas of daily living skills if necessary.

Estimated average _____ hours per week

_____ **Employment Specialist Services** include services necessary to support an individual in maintaining Employment. Services include: (1) periodic interventions on the job site to identify an individual's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when an individual's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the individual in acclimating to a new job.

Estimated average _____ hours per week

_____ **Work Support** is a therapeutic and supportive service provided to improve a member's ability to independently maintain productivity and employment. This service is commonly provided after a period of stabilization and encompasses adherence to workplace policies and productivity. It may also include training and assistance in areas such as hygiene, self-care, dress code, and related issues. Work Support is provided in a member's place of employment and may be provided in a member's home in preparation for work.

Estimated average _____ hours per week

_____ **Home Accessibility Adaptations** are those physical adaptations to the home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home.

(Describe in narrative)

_____ **Transportation service** offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170 (a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized.

(Describe in narrative)

_____ **Respite Services** provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite may be provided in the participant's home, provider's home or other location as approved by a respite agency or DHHS. Expenditures for this service may not exceed $1,000 per year.

(Describe in narrative)

Planning Team Recommendation for Waiver Services (Section 21)

The planning team recommends the following service categories. See plan narrative for details.

____ **Home Support** is direct support provided to improve and maintain a member's ability to live as independently as possible in his or her home. Home Support may be provided in a Licensed or unlicensed residential setting, in a Shared Living arrangement, or in any other residential setting. Home Support is direct support to a member and includes habilitative training and/or personal assistance (self-care, self management), development and personal well-being. Home Support may be provided as either a regularly scheduled "round the clock" service or as less intensive individual hours, or blocks of hours, of service.
(___ Per Diem) (Hourly, _____ hrs/week) (___ Shared Living) (___ Family-centered, __ persons served)

_____ **Community Support** is Direct Support provided in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and limited support in areas of daily living skills if necessary.
Estimated average _____ hrs./week

____ **Employment Specialist Services** include services necessary to support an individual in maintaining Employment. Services include: (1) periodic interventions on the job site to identify an individual's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when an individual's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the individual in acclimating to a new job.
Estimated average _____ hours per week

_____ **Work Support** is a therapeutic and supportive service provided to improve a member's ability to independently maintain productivity and employment. This service is commonly provided after a period of stabilization and encompasses adherence to workplace policies and productivity. It may also include training and assistance in areas such as hygiene, self-care, dress code, and related issues. Work Support is provided in a member's place of employment and may be provided in a member's home in preparation for work.
Estimated average _____ hours per week

____ **Home Accessibility Adaptations** are those physical adaptations to the home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home.
(Describe in narrative)

____ **Specialized medical equipment and supplies** include devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the MaineCare Benefits Manual. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the MaineCare Benefits Manual and exclude those items that are not of direct medical or remedial benefit to the participant
(Describe in narrative)

____ **Communication Aids** are devices or services necessary to assist individuals with hearing, speech impairments to effectively communicate with service providers, family, friends, and other community members. Communication Aids include:
a) Communicators (including repair and maintenance) such as direct selection, alphanumeric, scanning and encoding communicators;
b) Speech amplifiers (includes hearing aids), aids and assistive devices (including repair and maintenance) if not otherwise covered for reimbursement under other sections of the MaineCare Benefits Manual;
c) Facilitated communication. Providers **must** submit a written plan for DHHS's approval defining the facilitated communication services that will be offered to the Member. The provider of this service **must** have a Certificate of Clinical Competence-Speech Pathology (CCC-SP)
(Describe in narrative)

____ **Non-Traditional Communication Consultation** is provided to members and their direct support staff and others to assist them in to maximize communication ability as determined from assessment. The goal is to allow

for greater participation in the service planning process and to enhance communication within the member's environment. The provider of this service **must** be a Certified Visual Gestural Communicator.
(Describe in narrative)

____ **Non-Traditional Communication Assessments** determine the level of communication present via gesture, sign language or unique individual communication style. The assessment examines signed or gestured vocabulary for every day objects or actions and. the ability to combine gestures, as well as the ability to understand similar communication. Assessment recommendations are made to optimize communication to maximize social integration. The provider of this service **must** be approved by The Department of Health and Human Services Office of Deaf and Multi-cultural Services.
(Describe in narrative)

____ **Consultation Services** are services provided to persons responsible for developing or carrying out a member's Personal Plan. Consultation Services include**:**

a) Reviewing evaluations and assessments of the member's present and potential level of psychological, physical, and social functioning made through professional assessment techniques; direct interviews with the member and others involved in the Personal Plan; review and analysis of previous reports and evaluations, and review of current treatment modalities and the particular applications to the individual member.
b) Technical assistance to individuals primarily responsible for carrying out the member's Personal Plan in the member's home, or in other community sites as appropriate.
c) Assisting in the design and integration of individual development objectives as part of the overall Personal Planning process, and training persons providing direct service in carrying out special habilitative strategies identified in the member's Personal Plan.
d) Monitoring progress of a member in accordance with his or her Personal Plan and assisting individuals primarily responsible for carrying out the member's Personal Plan in the member's home or in other community sites as appropriate, to make necessary adjustments.
e) Providing information and assistance to the member and other persons responsible for developing the overall Personal Plan.

___ OT ___ PT ___ SLP ____ Psych

____ **Counseling** is a direct service to assist the member in the resolution of the member's behavioral, social, mental health, and alcohol or drug abuse issues. Counseling services, as recommended in the Personal Plan, are approved by DHHS. The provider of this service **must** be a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Professional Counselor (LCPC).
(Describe in narrative)

____ **Crisis Intervention Services** are direct intensive support provided to individuals who are experiencing a psychological, behavioral, or emotional crisis. The scope, intensity, duration, intent and outcome of Crisis Intervention **must** be documented in the Personal Plan. Crisis intervention is commonly provided on a short-term intermittent basis.
(Describe in narrative)

____ **Crisis Assessment** is a comprehensive clinical assessment of a member who has required intervention by the state Crisis Team on at least three occasions within a two-week period. The assessment includes: a clinical evaluation to identify causes or conditions that may precipitate the crisis, specific crisis prevention activities, and to develop a plan for early intervention and stabilization in the event of a crisis. The required members of a clinical team are a psychiatrist or licensed psychologist and a clinical liaison. Depending upon client need other team members may include: physician, occupational, physical or speech therapist.
(Describe in narrative)

____ **Transportation Service** offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170 (a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the member's service plan. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized.
(Describe in narrative)

Personal Plan Approval

Date:

Dear;

A copy of the Person-Centered Plan for _____ dated _____ is enclosed for your approval. Please check the appropriate box below to show if you approve the plan, or do not approve the plan. Return this letter to me in the enclosed self-addressed envelope within ten (10) business days. If you do not respond within 10 days, this may result in disruption of services.

☐ I approve the plan. I understand that I may revoke my approval of any or all parts of the plan at any time

☐ I do NOT approve the plan and will get in touch with you to discuss it.

_____ _____

Service Recipient or legal guardian date

Thank you for your assistance.

Sincerely,

SAMPLE CRITICAL INFORMATION SHEET
Inform Case Manager immediately of any changes

Last Name _____ **First Name** _____ **MI** _____

Residence _____ Phone _____
Street: _____
City: _____ ____ ZIP _____

Caseworker _____

Birthdate _____ **SSN** _____ ____ _____
Mainecare # _____
Medicare #: _____

DAY PROGRAM _____ Phone _____

EMPLOYER _____ Phone _____

GUARDIAN _____ Phone _____
Guardianship type: _____
CO-GUARDIAN: _____ Phone _____

Rep payee: _____ Phone _____

Emergency Contact: _____ Phone _____

Next of kin: _____ Phone _____
Relationship: _____

OAB Correspondent: _____ Phone _____
Street: _____
City: _____ ____ ZIP _____

Location of current critical medical info: _____

Primary Physician _____ Phone _____

Psychiatrist: _____ Phone: _____

Pharmacy _____ Phone _____

CRITICAL MEDICAL/PERSONAL INFORMATION
ALLERGIES TO MEDS _____
OTHER ALLERGIES _____
SEIZURES? (yes/no) ___ SEIZURE TYPE _____
DIABETIC? (yes/no) ___ INSULIN INJECTION DEPENDENT? (yes/no) ____
SOURCES OF SIGNIFICANT DANGER TO PERSON OR OTHERS (e.g., combustibles, sexually assaultive) _____

Communication Preferences

Other critical information

PCP Data Collection Form

02.01.07

Region: _____ **Consumer:** _____ **Planning Date**: _____

ISC:_____ **Date Received at District Office:** _____

Planning Process Coordinator: _____ **PPC Agency** _____

Day Activity Type: Center Based ☐ Community Based ☐ Whole Life ☐ None ☐ If none, state reason_____

Guardianship type: Full Public ☐ Limited Public ☐ Full Private ☐ Limited Private ☐ Self ☐

Guardian(s) Name(s): _____ The Guardian is DHHS ☐

OAB Correspondent: _____ No OAB Correspondent ☐

Planning Process Choice: Person-Centered Planning ☐ Other Planning Process ☐

1.The following individuals participated in the preplanning process. Please indicate whether the individual participated in preplanning discussions and/or returned the completed Response Sheet for Essential PCP Information (*Response Sheet*)

	Response Sheet	Preplanning
a. Person/Self		
b. Guardian		
c. ISC/Community CM		
d. OAB Correspondent		
e. Advocate		

2. A summary of the Response Sheet is attached to the PCP: Yes ☐ No ☐ N/A ☐ Consumer/guardian chose not to have Response Sheet used

2a. The results from the Summary of the Response Sheet were used in **preplanning**: Yes ☐ No ☐

2b. The names of the individuals completing Response Sheet are listed on the summary. Yes ☐ No ☐ Partial ☐

3. During the **preplanning process**, did the consumer identify a sensitive issue to be discussed in another forum with or without the consumer present? Yes ☐ No ☐

3a. Was the sensitive issue discussed in another forum? Yes ☐ No ☐

4. Reportable events were reviewed during **preplanning process**: Yes ☐ No ☐ N/A, no reportable events ☐

4a. The time frame reviewed for reportable events: _____to _____

5. Did the consumer have a crisis event in the last 12 months that met criteria for an IST? Yes ☐ No ☐(If no, go to Question 6)

5a. Did an IST take place for the individual in the previous 12 months? Yes ☐ No ☐

D ate(s) of IST(s): _____

5b. Did the planning document include a review of all IST recommendations? Yes ☐ No ☐

5c. Did the planning document outline the team's responses to IST recommendations? Yes ☐ No ☐

6. The following people were invited, notified, attended or participated in the **planning meeting**: (check all that apply)

	Invited/ Notified	Attended (physically present at planning meeting)	Participated (may include telephone, correspondence)
a. Person/Self			
b. Guardian			
c. ISC/Community CM			
d. OAB correspondent			
e. Advocate			

7. If the individual does not have a traditional day program, does the plan include a description of the ongoing activities of the individual's whole life program? Yes ☐ No ☐ N/A ☐

8. The planning document reflects all **needs** have been identified. Yes ☐ No ☐

8a. Those needs not addressed in Continuing Services are reflected in an action plan. Yes ☐ No ☐
The action plan(s) contains the following information:
Target date for each action plan (when) Yes ☐ No ☐
Name of person responsible for each action plan (who) Yes ☐ No ☐
How the need is to be achieved Yes ☐ No ☐

9. Does the planning document identify all unmet needs? Yes ☐ No ☐ No unmet needs identified ☐ **(If none, go to 9c)**

9a.Number of unmet needs as identified in the plan. _____

9b.The planning document includes an interim plan for each unmet need. Yes ☐ No ☐

9c. Were there unmet needs identified during the previous planning cycle(s)? Yes ☐ No ☐

9d. If yes to 9c, have those unmet needs from the previous planning cycle(s) been met? Yes ☐ No ☐

9e. If 9d is no, are those unmet needs addressed in this planning document? Yes ☐ No ☐

10. The planning document reflects all **desires** have been identified. Yes ☐ No ☐

10a. Those desires not addressed in Continuing Services are reflected in an action plan. Yes ☐ No ☐
The action plan(s) contain the following information:
Target date for each action plan (when) Yes ☐ No ☐
Name of person responsible for each action plan (who) Yes ☐ No ☐
How the desire is to be achieved Yes ☐ No ☐

11. The plan documents Continuing Services supporting the individual's needs/desires identified in the body of the PCP? Yes ☐ No ☐

11a. Does the Continuing Services form contain target dates & the name of the individual responsible for assuring the service is delivered for each continuing service? Yes ☐ No ☐

12. Does the plan include the name of the person responsible to monitor medical/dental services? Yes ☐ No ☐

12a. Is there a prescribed deviation from an annual medical examination? Yes ☐ No ☐

12b. Is there a prescribed deviation from an annual dental examination? Yes ☐ No ☐

13. Does the plan include the name of the person responsible for updating the critical information and for reporting changes to the ISC/Community CM monthly or sooner if medication changes occur? Yes ☐ No ☐

14. The Individual Service & Supports Assessment from the EIS is attached to the PCP? Yes ☐ No ☐

14a. The assessment reflects all needs and services & supports indicated in the PCP? Yes ☐ No ☐

14b. The assessment was updated within 10 business days after the planning meeting? Yes ☐ No ☐ Updated on _____

Signature indicates this document including the attached Revision Tracking Sheet has been reviewed and is complete and correct.

_____ ___ _____
ISC Date

_____ ___ _____
Reviewer Date

_____ ___ _____
Reviewer Date

_____ ___ _____
District Supervisor Date

Resources for Person-Centered Planning

Planning With People: A User-Friendly Guide to Maine's Person-Centered Planning Process. By Thomas Ward and Susan McKowen O'Connor. Maine Department of Mental Health, Mental Retardation and Substance Abuse Services and the Consumer Advisory Board, 1996. Available from DHHS Developmental Services

Companions on the Journey: A Resource Guide for those who would engage in the process of Person-Centered Planning. By Paula Curran Sharp. Available from DHHS Developmental Services

It's Your Life, What's Your Plan? A Consumer Guide to Person-Centered Planning. Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, 1997. Available from DHHS Developmental Services

It's Your Life, What's Your Plan? A Consumer Guide to Person-Centered Planning (symbols version). By Rod MacInnes. Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, 2000. Available from DHHS Developmental Services

A Workbook for Personal Planning. Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, 1997. Available from DHHS Developmental Services

Making Futures Happen: A Manual for Facilitators of Personal Futures Planning. By Beth Mount. Minnesota Governor's Council on Developmental Disabilities, 1994. 370 Centennial Office Bldg., 658 Cedar St. St. Paul, MN 55155. (651) 296-4018. www.mnddc.org

It's My Choice…. By William T. Allen, Ph.D.. Minnesota Governor's Council on Developmental Disabilities, 1994. 370 Centennial Office Bldg., 658 Cedar St. St. Paul, MN 55155. (651) 296-4018. www.mnddc.org

Direct Support Professional: Adult Developmental Services. Module 7 "Planning With People". Maine Dept. of Behavioral & Developmental Services and Behavioral Health Sciences Institute, 2002. Available from Behavioral Health Sciences Institute (207) 684-4589 or www.bhsi.net

A Little Book About Person-Centered Planning. John O'Brien and Connie Lyle O'Brien, eds.. Inclusion Press, 1998 www.inclusion.com

Implementing Person-Centered Planning Vol. II: Voices of Experience. John O'Brien and Connie Lyle O'Brien, eds.. Inclusion Press, 2002 www.inclusion.com

Roles Based Planning: A Thoughtful Approach to Social Inclusion and Empowerment. By Scott Ramsey. Developmental Disabilities Resource Centre of Calgary, 2005. scottr@ddrcc.com

Make A Difference: A Guidebook for Person-Centered Direct Support. By John O'Brien and Beth Mount, Inclusion Press, 2005. www.inclusion.com

Person-Centered Planning: Finding Directions for Change Using Personal Futures Planning. By Beth Mount, Capacity Works 2000. www.capacityworks.com

Publishers

Brookes Publishing Co. PO Box 10624, Baltimore, MD 212-85-0624. www.brookespublishing.com

Capacity Works PO Box 271, Amenia, NY 12501-0271. (888) 840-8578. www.capacityworks.com

Inclusion Press 24 Thome Crescent, Toronto, Ontario M6H2S5, Canada (416) 658-5363. www.inclusion.com

Training Resource Network PO Box 439, St. Augustine, FL 32085-0439. (904) 823-9800. www.trninc.com

Additional Resources

These materials are not specific to Person-Centered Planning, but may help inform participants and the process.

Pineland's Past: The First One Hundred Years. By Richard S. Kimball. Peter E. Randall, Publisher 2001. Box 4726, Portsmouth, NH 03802-4726. On sale at Pineland Visitor Center in Pownal, Maine and available at all public libraries in Maine

Power Tools. By Dave Hingsburger. Diverse City Press, 2000. 33 des Floralies, Eastman, Quebec J0E 1P0, Canada. www.diverse-city.com

First Contact: Charting Inner Space. By Dave Hingsburger. Diverse City Press, 2000. 33 des Floralies, Eastman, Quebec J0E 1P0, Canada. www.diverse-city.com

Part of the Community: Strategies for Including Everyone. By Jan Nisbet and David Hagner. Paul H. Brookes Publishing Co., 2000. PO Box 10624, Baltimore, MD 212-85-0624. www.brookespublishing.com

Your Values, My Values: Multicultural Services in Developmental Disabilities. By Lilah Pengra, Paul H. Brookes Publishing Co., 2000. PO Box 10624, Baltimore, MD 212-85-0624. www.brookespublishing.com

A Credo for Support. (VHS or DVD, 4 min.) by Norman Kunc and Emma Van der Klift. Axis Consultation & Training Ltd., 340 Machleary St., Nanaimo, British Columbia V9R 2G9, Canada. (250) 754-9939. www.normemma.com

Riding the Bus With My Sister. By Rachel Simon. Penguin Group USA, 2002. 375 Hudson St. NY, NY 10014

Make the Day Matter! Promoting Typical Lifestyles for Adults with Significant Disabilities. By Pamela Walker and Patricia Rogan. Brookes Publishing, 2007. www.brookespublishing.com

My Life, My Choice: Personal stories, struggles and successes with person directed living. (DVD, 28 minutes) Inclusion Press 2006. www.inclusion.com

Picture This. (VHS, 60 minutes) Maine Public Broadcasting, 2003. Vignettes of nine Mainers with significant disabilities. Available from DHHS Developmental Services

Functions of Person-Centered Planning Teams, as defined in Laws, Regulations, and Consent Decree

Note: The following are selected excerpts. They are not the compete text. Please go to the source for the complete text of any law or rule

I. State Law

http://www.mainelegislature.org/legis/statutes/34-B/title34-Bch5sec0.html

Sec. 12. 34-B MRSA §5001, sub-§3-C is enacted to read:

3-C. Personal planning. "Personal planning" means a process that assists and supports each person with mental retardation or autism in creating a vision for how to live in and be a part of the community.

Sec. 13. 34-B MRSA §5001, sub-§3-D is enacted to read:

3-D. Personal planning team. "Personal planning team" means the person with mental retardation or autism, the person's guardian, if any, the person's individual support coordinator or Case Manager and other individuals chosen or identified by the person to participate in personal planning.

Sec. 21. 34-B MRSA §5470-B is enacted to read:

§ 5470-B. **Personal planning**

1. **Right to personal planning.** Every adult with mental retardation or autism who is eligible for services **must** be provided the opportunity to engage in a personal planning process in which the needs and desires of the person are articulated and identified.
2. **Process.** The personal planning opportunities afforded to a person with mental retardation or autism pursuant to subsection 1 **must**:
   A. Be understandable to that person and in plain language and, if that person is deaf or nonverbal, uses sign language or speaks another language, the process **must** include qualified interpreters;
   B. Focus on the choices made by that person;
   C. Reflect and support the goals and aspirations of that person;
   D. Be developed at the direction of that person and include people whom the person chooses to participate. The planning process **must** minimally include the person, the person's guardian, if any, the correspondent, if any, and the person's Case Manager;
   E. Be flexible enough to change as new opportunities arise;
   F. Be offered to that person at least annually or on a schedule established through the planning process and be reviewed according to a specified schedule and by a person designated for monitoring;
   G. Include all of the needs and desires of that person without respect to whether those desires are reasonably achievable or the needs are presently capable of being addressed; and
   H. Include a provision for ensuring the satisfaction of that person with the quality of the plan and the supports that the person receives.
3. **Action plans and unmet needs.** The ongoing personal planning for a person with mental retardation or autism **must** include an action plan that describes the services to be provided, the process of providing the services and who is responsible for overseeing the provision of the services. In cases where resources required to address identified needs or desires are not available, the action plan **must** identify interim measures based on available resources that address the needs or desires as nearly as possible and identify steps toward meeting the person's actual identified needs.

   Unmet needs **must** be documented continually, collated annually and used for appropriate development activities on a district and statewide basis.
4. **Review of personal plans.** The person with mental retardation or autism or another member of the planning team may initiate a review of the person's personal plan when needed or desired.
   A. A review under this subsection **must** be done by meeting or by other means sufficient to address the needed or desired changes. The review **must** include the person, the person's guardian, if any, and the person's Case Manager. Invitations to participate may also be sent to others who

may be anticipated to assist the person in pursuing articulated needs and desires unless the person or a private guardian objects.

B. Events that could lead to the loss of the person's home, job or program and events defined in a departmental rule or in the person's plan **must** lead to a plan review.

5. Information from planning process. During personal planning, the department **shall** develop and record information about a person's needs, identify anticipated needs without regard to service availability, define necessary support services, recommend optimal courses of action and include plans for the active and continued exploration of suitable program or service alternatives based on the person's needs.

6. Implementation of personal plan. As part of its implementation, the personal plan **must** be agreed to by the person or the person's legal guardian. The department **shall** assist persons with the needs identified by their planning process to obtain housing, employment or other meaningful occupation, medical and other professional therapeutic services, recreational and vocational opportunities and educational services at the earliest possible time, insofar as resources permit.

34-BMRSA§5605 14 D re safety devices

D. Mechanical supports used in normative situations to achieve proper body position and balance are not considered restraints, but mechanical supports must be prescriptively designed and applied under the supervision of a qualified professional with concern for principles of good body alignment, circulation and allowance for change of position.

D-1. A device whose effect is to reduce or inhibit a person's movement in any way but whose purpose is to maintain or ensure the safety of the person is not considered behavioral treatment. Such a device may be used only in conformity with applicable state and federal rules and regulations and only:

(1) When recommended by a qualified professional after approval of the person's service plan;

(2) For an adult 18 years of age or older, when use of the device is approved by a review team composed of an advocate from the Disability Rights Center, a representative of the OADS and a representative of the OAB;

Sec. 27. 34-B MRSA §5610 is enacted to read:

§ 5610. **Service delivery**

1. Guiding service delivery. The delivery of services by providers of services and the department to persons with mental retardation and autism is guided by the following.

A. Persons with mental retardation or autism have the same rights as all citizens, including the rights to live, work and participate in the life of the community.

B. Community inclusion is achieved by connecting persons and their families, whenever possible, to local and generic supports within the community and by the use of residential services that are small and integrated into the community.

C. Real work for real pay for persons in integrated settings in the community is the cornerstone of all vocational and employment services.

D. Service delivery to persons with mental retardation and autism is based on the following fundamentals:

(1) Maximizing the growth and development of the person and inclusion in the community;

(2) Maximizing the person's control over that person's life;

(3) Supporting the person in that person's own home;

(4) Acknowledging and enhancing the role of the family, as appropriate, as the primary and most natural caregiver; and

(5) Planning for the delivery of community services that:

(a) Promotes a high quality of life;

(b) Is based on ongoing individualized assessment of the strengths, needs and preferences of the person and the strengths of that person's family; and

(c) Identifies and considers connections in other areas of the person's life, including but not limited to family, allies, friends, work, recreation and spirituality.

Note: "Defendants" means the commissioner of DHHS and the Director of Developmental Services, or their designees.

V. Statement of Principles

2. All services provided should have the goal of maximizing growth, development and social integration into the community.
4. Community integration is achieved by connecting individuals and families with local and generic supports within the community
7. Real work for real pay, in integrated settings, shall be the cornerstone of all vocational and employment services

VII. Personal Planning Process

1. … Defendants **shall** give each person the opportunity to engage in a person-centered planning process where the needs and desires of the person are articulated and identified. Personal desires and needs **shall** be recorded without respect to whether those desires are reasonably achievable or the needs are presently capable of being addressed. In cases where resources required to address identified needs or desires are not available, the planning team **shall** develop an interim plan based on available services which:
    a. addresses the needs or desires as nearly as possible, and
    b. identifies steps toward meeting the person's actual identified needs.
2. The planning process **shall** include participants chosen by the person and others who can be anticipated to assist the person in productive pursuit of articulated desires and identified needs. The planning process **shall** minimally include the person, his/her guardian, and his/her Individual Support Coordinator, with participation and/or input by friends, service providers, correspondents, advocates, and others. Unless the person objects, the correspondent and advocate **shall** always be invited to the planning meeting and to otherwise participate in the planning process. The Disability Rights Center shall receive notice of the formal commencement of all planning processes.
3. Each person **shall** be offered a planning process at least annually. Notification of this offer **shall** be given to the person's guardian, if any, and, unless the person has no guardian and objects, to the person's correspondent and advocate. Any refusal of the annual planning process **shall** be documented in the person's records.
4. Whenever needed or desired, the person or another member of the planning team may initiate a review of the person's plan.
    a. The review **shall** be done by meeting together or by other means sufficient to address the needed or desired changes.
    b. Any review **shall** always include the person and his/her guardian, if any. The Individual Support Coordinator **shall** be part of the review process. Unless the person has no guardian and objects, notification of any review **shall** be given to the person's correspondent and advocate.
    c. Events which **shall** lead to plan review include, but are not limited to, use of crisis intervention services, use of physical restraints, and events which could lead to loss of a person's home, job or program.
    d. Other events which **shall** lead to a plan review **shall** be identified by the planning team.
5. As part of the Individual Support Coordinator's monthly contact with the person, he/she **shall** inquire about any changes which have occurred, and any desires and needs that may affect the person's plan and which may cause a need for review.
6. The Defendants **shall** have responsibility for assuring that the above provisions are carried out and for maintaining suitable records of activities under each person's plan.
7. 'Suitable records' as specified above **shall** include each of the following elements:
    a. Records **shall** record personal needs and desires without respect to whether the desires are reasonably achievable or the needs presently capable of being addressed.

b. The person's written plan **shall** be provided to the person, his/her designees, and all persons identified as responsible for any significant activity pursuant to the planning process.
c. Defendants' activities and findings relating to the person's plan.
d. On a form clearly designated for the purpose of identifying unmet needs, a listing of each service or activity which cannot occur or is not occurring pursuant to a person's plan. Unmet needs **shall** be documented on a monthly basis by ADS and **shall** be collated quarterly and utilized for appropriate development activities on a District and statewide basis. These findings **shall** be made available to the Consumer Advisory Board.

XVI. 5. Correspondents shall have access to all living, work, and program areas and to all records related to the person or persons for whom they are the correspondent, other than personnel records, and to the personnel of any institution, facility, agency or other provider administered by the Defendants where the person or persons for whom they are the correspondent resides or participates in work or a program. Correspondents do not have access privileges to information or records confidential to any person or persons for whom they are not the designated correspondent.

1.C.(1) Three uses of any chemical restraint or physical holding within a two week period or other patterns of use requires the individual's **planning team** to convene to review the adequacy of the individual's behavioral intervention plan and services

1.D. Other Circumstances. On rare occasions, emergency measures not specified in these regulations may be required. In such instances, the following procedures **shall** be followed.

(3) Within two weeks of the use of such an intervention, the individual's **planning team shall** convene to review the use of the intervention. Such review **shall** be documented in the individual's record.

2.1.D. D. Moderately intrusive interventions **must** be part of the written plan and approved by the **planning team**. The Review Committee, following review and approval by the planning team, **must** approve severely intrusive interventions.

4. Meetings of the Planning Team to Develop or Review Behavioral Interventions

A. When it is proposed that a particular intervention be systematically used to change or eliminate a specific behavior of an individual, written documentation of the proposed use of the intervention **must** be included in the individual's planning process. A **planning team must** approve this process.

B. The **planning team must** always include the individual and the guardian when one has been appointed. It **must** also include a caseworker or other Departmental representative, who **must** coordinate the inclusion of any other relevant planning team members. The planning team **must** include representatives of every site at which the behavioral treatment procedure is to be implemented.

C. Pursuant to 34-B M.R.S.A. § 5605(13), the **planning team must** evaluate factors that may be contributing to the occurrence of the behavior. Such factors may include but are not limited to

(1) Illness,
(2) Psychiatric conditions, and
(3) Significant life events.

In the event that factors such as those listed above exist, the **planning team** may still determine that a behavioral plan is indicated, but the planning team **shall** include, as part of the plan, its rationale for so deciding.

8. Severely Intrusive Interventions

B. Severely intrusive behavioral plans may never be implemented on an informal basis. They may only be instituted following

(1) The consent of the individual or guardian if one has been appointed,

(2) **Planning team** approval. A member of the Disability Rights Center **must** be present as a member of the planning team,

G. Prior to approving a plan for a severely intrusive intervention, the **planning team must** identify a Licensed Psychologist or Psychiatrist who will recommend the intervention

Sections 21 and 29 (The language in both sections is identical, but numbering differs. The text here is from Section 21. For the text of section 29, go to the link listed above)

21.02-16 **Personal Plan** is a member's plan developed at least annually that lists the services offered under the waiver benefit. The Personal Plan may also include services not covered by the waiver but identified by the member. Only services included on the Personal Plan are reimbursable. The Personal Plan may also be known as a Person-Centered plan, a service plan, an individual support plan, or an individual education plan, as long as the requirements of Section 21.04-2 are met.

21.04-2 **Plan Requirements**

The ISC will ensure that the Planning Team is convened to initiate development of the Personal Plan prior to services being initiated. The plan **must** be less than six (6) months old. If older than six (6) months, supporting documentation **must** accompany the plan that discusses the current services being provided under this section, subject to ISC approval. The Personal Plan **must** describe at a minimum:

A. All MaineCare Home and Community waiver benefit services determined medically necessary by the team including all other services that may not be covered under this section but the member identifies and may pursue;
B. The frequency of provision of the services;
C. How services contribute to the member's health and well-being and the member's ability to reside in a community setting;
D. The member's goals for strengthening and cultivating personal, community, family, and professional relationships;
E. The role and responsibility of the Direct Support Professional, the Employment Specialist and the member's other service providers in supporting the member's goals, including goals for strengthening natural and supportive personal, family, community and professional relationships; and
F. Signatures of the participants; in order for the Plan to be authorized the Plan **must** include signatures of the member, guardian, if applicable, and Case Manager.

The Personal Plan will be used by DHHS to develop the Summary of Authorized Services (SAS), which is a component of the Plan, and which identifies the type and units of authorized services the member may receive under this Section. If more than one provider is reimbursed for the same category of direct support activities, an explanation of the differences in roles and responsibilities of each provider and how services will not be duplicated is required.

21.04-3 **Planning Team Composition**

Each member or guardian will determine the composition of the Planning Team. Planning will occur in a manner that is respectful and reflective of the member's preference. The planning team may include the following members, if applicable:

A. Plan facilitator;
B. Case Manager or Individual Support Coordinator;
C. The member;
D. The member's parent, guardian or Correspondent;
E. The member's advocate or friend or any additional individual invited by the member;
F. Operator of the member's home or a Direct Support Professional providing services to the member;

G. Staff from the member's Community Support, Work Support or Employment Specialist Services Provider; and

H. Any professionals involved or likely to be involved with the member's Personal Plan.

21.04-4 Updating the Personal Plan

The member's Personal Plan **must** be revised and updated at least annually, when there is a revision or update to the member's SAS, or when other significant changes occur relating to the member's physical, social, or psychological needs, or the member's significant progress toward his or her goals. The ISC will reconvene the Planning Team to revise and update the Personal Plan. Planning meetings **shall** be held both prior to and subsequent to the planned move of a member to a new residence in order to coordinate supports and services and to evaluate the member's satisfaction with the change.

--NOTES --